GS ON HEALTH CARE REFORM

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HEARINGS

BEFORE THE

SUBCOMMITTEE ON
LABOR-MANAGEMENT RELATIONS

OF THE

COMMITTEE ON EDUCATION AND LABOR
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

HEARINGS HELD IN WASHINGTON, DC, FEBRUARY 2, 10, 21, AND 22, 1994

Serial No. 103–105

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H.R. 3600—"THE HEALTH SECURITY ACT—IMPACT ON WORKERS [INCLUDING PART-TIME, SEASONAL AND TEMPORARY EMPLOYEES] AND RETIREES"

WEDNESDAY, FEBRUARY 2, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The committee met, pursuant to notice, at 10:15 a.m., Room 2261, Rayburn House Office Building, Hon. Pat Williams, Chairman, presiding.

Members present: Representatives Clay, Martinez, Payne, Unsoeld, Klink, Green, Woolsey, Romero-Barcelo, Roukema, Gunderson, Barrett, Fawell, Ballenger, Hoekstra, McKeon, and Goodling.

Staff present: Phyllis Borzi, counsel for Employee Benefits; Susannah Ringel, counsel; Jon Weintraub, staff director; Fred Feinstein, chief counsel; and Gail Brown-Hubb, staff assistant.

Chairman WILLIAMS. Good morning. I call this hearing of the Labor-Management Relations Subcommittee, which is continuing hearing on health care reform, to order. Since Congress adjourned late last year, this subcommittee has been traveling across the country listening to the concerns of business, most particularly small business, hospitals, doctors, nurses, other health professionals, and State and local officials.

We have, of course, also heard the moving stories from individuals and families who are struggling, seriously struggling, to provide themselves with basic health care coverage. Some, we found, have insurance that really doesn't cover them adequately but covers only a very small portion of their medical needs. Others have to pay so much out of their own pocket for care, that they wonder what they're getting for the premiums they have paid for.

We've heard from people that have lost their coverage when they lost their jobs. We've heard from people who have lost their coverage because they or a member of their family had to use coverage or got seriously ill and then their coverage was taken away. We heard from people that think that the insurance scheme in America has been turned on its head therefore.

We heard from people who are in what they call job lock. They can't move because they've got a preexisting illness and it means, if they move, they can't get insurance at a reasonable cost to them and their employer, so they're in job lock.

Some have told us that the constant jump in premiums has forced them to drop coverage. We've heard from small business folks and their employees. They told us that they were terrified as to what might happen to them if their employer decided to eliminate their health coverage.

The subcommittee has been busy and we've heard from an awful lot of people during this recess. And we've learned a lot. We've learned about the parts of the President's bill that have overwhelming support, and we've heard from folks about the parts of the President's bill that they would like to see adjusted.

Guaranteeing every American the right to a comprehensive package of benefits that can never be taken away has been essential to everyone that has come before us—virtually everyone. Continuing the current voluntary system, even with small group insurance market reforms, say the majority of people who have come before this subcommittee simply won't provide them with the security that they believe they deserve.

Today the subcommittee will focus on how workers and their families, but most particularly the question of workers who retire somewhat early, how we can protect those workers and their families and how they would be affected by the current proposals before Congress.

We will also hear recommendations from some of our witnesses about how to protect part-time workers. And many, if not most, part-time workers in America are women. That doesn't, I think, make this issue any more important, but it does focus it on one segment of the American population.

So we look forward to hearing from our witnesses. Let me see if some of my colleagues have an opening statement. Mrs. Roukema.

Mrs. ROUKEMA. Yes. Thank you, Mr. Chairman, I do have an opening statement, and I would like to acknowledge that the series of hearings that you've held, both here in Washington and, most particularly, the field hearings during the recess, were very useful and constructive, and I believe the record of those hearings will provide an essential component of the health care debate and the ensuing bill or legislation, whatever form that may take.

I would suggest to you that I heard probably more objective criticism of the President's proposal than perhaps I could have anticipated, and maybe more than you heard. Maybe my ears were perked up to some of those criticisms. But in any case, it has represented a broad spectrum of opinion.

And here we are here today, while the Nation is—or at least the press—I don't think the Nation is, but the press is debating the semantics of whether we have a health care crisis or a problem or an insurance crisis. But in any case, I think we all know what we're talking about. There are problems out there.

I would like to digress a little bit and put it in another context, too, Mr. Chairman. Because of recent articles, such as David Broder's article, called "Winners and Losers," that was published and syndicated across the country in early January, and today, Mr. Robert Samuelson's column in the Washington Post, I believe it was entitled, "The Dishonest [and Nasty] Health Care Debate," both of which articles very much reflect some of my own thinking on the matter.

And I believe what both those articles bottom-line say, at least my interpretation of it, is that no one has truly or openly and candidly focused on what may be the bottom line for most Americans, and that is the quality of care in the future as compared to what they now enjoy.

And sometimes I feel like I'm a voice crying in the wilderness calling attention to quality issues, and here I even refer to some of my colleagues who like to refer to them as "Cadillac plans," and I look at them and I say, well, that's what Americans have enjoyed and that's what they expect to continue to enjoy.

We can ration care and we can save money all kinds of ways, including pushing women out of maternity rooms postpartum after 24 hours, and then you remember, Mr. Chairman, the hospital administrator in Billings, Montana, who started to brag to me that, my goodness, Congresswoman, 24 hours is nothing, we're experimenting with 12 hours.

And I told him I didn't want to hear that. After all, we could save lots of money if we just let women have the babies out in the fields and go back to picking rice right afterwards, but that's going back to the Dark Ages of medicine.

Why do I bring this up? I bring it up because I think we have got to face that the issue that the American people are really concerned about is the quality of care and whether or not they're going to get it at a price they can afford, and whether or not it's just going to simply mean that they're going to pay more for their health care and get less after all of this is done.

And I'm afraid, Mr. Chairman, that that's what a lot of this rhetoric comes down to. And that's a bipartisan statement; it's on both sides of the aisle, I'm saying. And that was the Samuelson question. That's by way of background; that's putting the focus of the debate as I see it.

But we have some very real questions here today, and I am very grateful for them because they deal probably most directly with this committee's jurisdiction, and that is the question of the so-called early retirement subsidy, or buyout, whichever you want to describe it, that's included under the President's plan. I have many questions about it, and I am grateful for this hearing.

I understand that the provision was designed to relieve certain employers from health insurance costs that they may now incur for their former employees. What is the health policy reasoning behind this particular transfer of costs—and it is a transfer.

At nearly all of our hearings, we have heard employers, unions, and providers and others express their concern over the current cost shifting that occurs under the present system. But this early retiree provision will certainly cost many billions of dollars. Just as certainly, someone else will have to pay for that cost. And will it be, in other words, another additional form of cost shifting?

The Health Security Act says that these transfer payments from the Federal Government to the regional alliances will be capped. I don't quite know what that means. If the actual premium costs for the early retirees exceed the arbitrary budget caps, then it would seem that an additional form of cost shifting will occur to both the individuals and employers who are required to continue paying for the cost of the benefit offered under regional alliances.

There are numbers of other questions, Mr. Chairman, which I will raise at the appropriate time during this discussion. I will abbreviate my opening remarks, but request that the full text of my opening comments be included in the record, and we shall allow as much time as possible for questioning our witnesses. Thank you, Mr. Chairman.

Chairman WILLIAMS. Thank you. Any opening statements that any of the members wish to submit for the record will of course, without objection, be made part of the record. Does any member on the Democratic side wish to make an opening statement? Mr. Romero?

Mr. ROMERO-BARCELO. Mr. Chairman, I would like to make a few comments, and I would like to, first of all, thank the Chairman and commend him for the outstanding work that was done during the recess. We held hearings, field hearings, in Montana, in Hawaii, in Los Angeles.

I know the minute one mentions Hawaii, it seems like right in the middle of winter, it's a nice trip to go to Hawaii, but I was witness to the fact that the schedule was so intense, like in Maui, I arrived at the hotel 11 p.m. at night, and the next morning at 6 a.m., I was leaving to catch the plane. That's not much of a vacation, if that's what some people believe.

And, Mr. Chairman, I know you were sick with walking pneumonia, and yet you were there at all the hearings, and it seemed interminable hearings. But the hearings were extremely interesting and also educational.

In Hawaii, we were looking at a program which is similar, or at least had been used as one of the examples for the President's proposal. And we saw the rural health care system in Hawaii, and we saw the rural health care system in Montana. We saw the problems in the city, in the inner city, in the poor areas in East Los Angeles. And the testimonies were very, very educational, and all kinds of testimony.

One of the things that came through, that, for instance, Hawaii was the only place where people were not complaining about not having insurance. It was the only place where we found that. In the other areas, we found continuous testimony of people who were concerned because they were not covered, and they couldn't be covered because of preexisting conditions.

And that is one of the reasons why we want this health care plan for America, to make sure that when someone loses a job, he and his family—she and her family—are not left out in the cold without insurance, and then when they get back to another job, they have to wait at least six months before they begin to be insured. If they have a preexisting condition, and that includes something as simple as the beginning of diabetes, those persons are not insured—are uninsurable.

Well, it's something that cannot be tolerated and allowed in this day and age. And people who are healthy, well, they want their Cadillac plans. Fine. But also what are we going to do about those other millions of U.S. citizens who are not covered or cannot be covered? That's why we need some kind of health care reform.

And we were educated in these hearings, and we wished that—it would have been a good thing if all of us could have been there

because I think that we learned a lot, and we came—at least I did—I came back from those hearings more convinced than ever that something has to be done.

The President's proposal is right there before us. We know it's going to be submitted. There are going to be amendments and there are going to be changes, but I just hope that this year, before the end of this session, we will have a health care reform where every American is covered. Otherwise, I think it will be a shame on the Nation if we cannot come out with some kind of health care reform where everyone is insured no matter what happens. And if people go bankrupt, then cannot afford a plan, they will also be covered.

In Hawaii, we got this group of small businessmen that came over to testify, and they were against the plan. They were voicing all kinds of objections. When I explained to them that any business with less than 25 workers, nowadays, where their average salary is less than $15,000, what they will be paying is about a dollar-something per day per worker, they couldn't believe it.

And then afterwards, they came over to me and, oh, we didn't know that, and we apologize for what we said, but anyway, we don't like it being imposed upon us. That was their basic position. But unless somebody imposes it, we are going to have those uninsured people and those uninsured families out there.

I just want to leave those thoughts with you, and I once again want to thank the Chairman for the work that he did and commend him for the dedication which I saw during all these hearings, and how with pneumonia he was going to the hearings and sitting there for long hours. And we just felt very proud of you. Thank you.

Chairman WILLIAMS. Thank you very much. I appreciated the gentleman accompanying us on the days of hearings in those three States. We were also in Pennsylvania with Mr. Goodling, Wisconsin with Mr. Gunderson, New Jersey with Mrs. Roukema, for a second round of days of hearings.

Any member on this side who wishes to make an opening statement?

[No response.]

Chairman WILLIAMS. Any other member on our side? Ms. Woolsey?

Ms. WOOLSEY. Thank you, Mr. Chairman. I think you still need health care. I can hear it. You don't sound well.

I would like to welcome our distinguished panel and members and thank them for bringing their voices to call for progressive health care reform. I have had the pleasure over the past year working with Labor to work on the pressing issues of this Nation. We have been successful with family and medical leave, and we're going to be working on welfare reform together, and now health care reform. And I want to commend you for your unflagging effort on behalf of America's working men and women.

As you know, I have been a strong supporter of the single payer approach to health care reform, an approach which has been endorsed by many labor unions, and I am pleased to see favorable reference to the single payer plan in Mr. Bieber's testimony today.

I agree that the Nation must move in that direction to have universal coverage and in order to curb our health care spending.

One reason I advocate the single payer system is because it ensures comprehensive benefits for everyone. And on that point, I would like to congratulate the labor unions. Unions long ago set a shining example to this Nation by offering their members a full range of health care benefits.

And I firmly believe that we should use these health care plans as models for the final benefit health care plan we have for this Nation. We should present Americans with benefits equal to or better than what we have now and what labor has set as our model.

I would also like to extend a special welcome to Ann Kolker from the National Women's Law Center. She is going to be talking today, and I have been working closely these past months with the law center to craft child support assurance legislation, and I want you to know, their work has been topnotch.

Ms. Kolker and I share a desire to ensure that health care reform works particularly for women—not only for women, but for women. Women must have equal access to high quality care, must be able to afford health care, given their traditionally part-time work and lower wages, and must be offered comprehensive benefits, including a full range of family planning and reproductive health care services.

I want to stress that in order for health care reform to be truly successful, women must be brought into the process from the very beginning and help design every element, from the benefits package to the delivery system. That is a priority of mine, and I look forward to working with Ann and other women's groups to make sure it happens.

Thank you again, Mr. Chairman, and welcome, panelists.

Chairman WILLIAMS. Thank you very much. Mr. Martinez.

Mr. MARTINEZ. Thank you, Mr. Chairman. You know, it was just a few short months ago I can remember that everybody was proclaiming that there was a health care crisis. And all of a sudden, because now we're going to get into the really heavy debate on the issue, there is all of a sudden, in some people's minds, no longer a health care crisis.

Well, I guess health care crisis is like anything else. If you've got health care and you don't develop a catastrophic health problem—and I remind everybody that not too long ago, we recognized that there was a catastrophic health care problem and we subsequently passed legislation. It wasn't good legislation and we had to repeal it, but the idea is that we did recognize that there was the health care crisis there.

And like I said before, if you don't develop that kind of a crisis, then I guess in your mind there is none, because you're fully insured, fully covered, you don't have to worry about it. But if you're underinsured because of the high cost of plans, and if you're one of those people that's not insured at all because individual coverage is too damn high, then there is a crisis—yes, there is a crisis. If you're without it, there is a crisis.

And I can remember in my young life, when I left employment that had coverage and was for a period of time without coverage and my daughter developed double pneumonia and ended up in the hospital in an oxygen tent and then I saw the bill afterwards, well, to me there was a crisis, because I had to pay that bill. And so I

know darn well that there are a lot of people out there suffering the same kind of situation.

Now, moreover, the rapidly rising cost, and nobody can argue that the cost isn't rising rapidly, that is not controlled or contained is part of that crisis. The President's plan tries to do that, and if you consider that against the diminishing services that are being provided, then there is a health care crisis.

The fact that some people die early or die because they can't afford to go to a doctor should tell us that there is something happening out there that we need to take care of. And I don't think we can just blame the insurance companies any longer. I think everybody involved shares a little bit of the blame, and we're going to share the biggest blame if we don't do something about it. Thank you, Mr. Chairman.

Chairman WILLIAMS. Thank you. Anyone else on either side?

Well, let's move to our first panel. Will Mr. Bieber and Mr. Sweeney and Mr. McEntee come forward, please. Owen Bieber is the president of the United Auto Workers, John Sweeney is the president of the Service Employees International Union, and Gerry McEntee is president of the American Federation of State, County, and Municipal Employees. It of course is a pleasure to have you three gentlemen, representing so many workers in this country, come before our committee.

President Bieber, why don't we begin with you.

STATEMENTS OF OWEN BIEBER, PRESIDENT, UNITED AUTO WORKERS; JOHN J. SWEENEY, PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION; AND GERALD McENTEE, PRESIDENT, AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES

Mr. BIEBER. Thank you very much, Mr. Chairman and members of the committee. On behalf of the UAW, I would like to thank you for the opportunity to present our views on President Clinton's health care reform proposal and its impact on workers and retirees.

The UAW believes that the Clinton proposal is good for workers, good for employers, and good for the entire country. We strongly support the President's proposal. It contains a number of basic principles which the UAW has long supported.

Number one, universal coverage. The Clinton plan would guarantee comprehensive health care benefits to all Americans. Everyone would be entitled to this coverage, regardless of income, health, employment status, age, or where they reside. The UAW has long believed that health care should be a basic right to all Americans. We commend the President for his courage in making this principle a central component of his proposal.

We are also pleased with the breadth of the guaranteed benefits package. Universal coverage is meaningless unless it includes the full range of family-wide health services.

Second, cost containment through enforceable budget. The Clinton plan would contain escalating health care costs through the formation of large purchasing pools and the standardization of claims forms. Most importantly, however, the Clinton plan would also establish a back-stop national health care budget that would gradu-

ally reduce the rate of growth in health care costs, both in the private sector and under Medicare and Medicaid.

We strongly support the principle of enforceable health care budgets. We believe this is the only way to prevent health care costs from continuing to spiral out of control.

Third, level playing field: employer mandate, and community rating. The Clinton health plan would establish a level playing field by requiring all companies to contribute to the cost of health care for their employees and by requiring health care plans to use community rating. This would eliminate cost shifting between employers. Furthermore, companies and families would no longer be penalized just because their workers or members are older or develop a serious medical condition.

Fourth, retiree health care. The UAW strongly supports the provisions of the Clinton health care plan dealing with early retirees between the ages of 55 and 65. We view this as one of the most critically important components of the President's plan.

During the past decade, we have witnessed dozens of cases where employers have abruptly canceled or reduced health insurance coverage. As a result, retirees have been forced to live with a drastically reduced standard of living.

This tragic situation has been caused in part by the fact that many of the companies that provide coverage to early retirees face competition from foreign companies which operate under national health care programs that distribute the burden of retiree health care costs across the entire society.

In addition, these companies often face competition from younger domestic companies which have a much lower ratio of retirees to active workers, and therefore do not have to bear the same burden of retiree health care costs.

The Clinton health plan would address the problems associated with providing coverage to early retirees in several ways. First, it would guarantee health coverage for early retirees just like the rest of America. Thus, early retirees would no longer have to fear the reduction or elimination of their health benefits.

Second, the Clinton plan would finance this coverage in an equitable manner by spreading these costs uniformly throughout society. In addition to being fair, this would also play an important role in restoring the competitiveness of many sectors of the American economy.

Five, limits on family costs. The UAW supports placing limits on the premiums and cost sharing which families are required to pay for health care. We applauded the administration's commitment to this principle. However, we urge the administration and Congress to consider lowering the cap on family premiums from 3.9 to 2 percent of wages.

Number six, tax cap. We commend the administration for preserving the tax-free status of most benefits. In rejecting suggestions that they should support a tougher tax cap on health care benefits, the First Lady has forcefully expressed the view that it would be wrong to subject 35 million Americans to a substantial tax increase.

The taxation of health care benefits would result in a large tax on the middle class. It also would lead to a reduction in important

health insurance coverage. And it would not be an effective mechanism for slowing the growth in health care costs.

In conclusion, Mr. Chairman and members of the committee, the UAW appreciates the opportunity to testify before this subcommittee. We strongly support President Clinton's health care reform proposal. We believe it embodies a number of principles which are necessary to provide genuine reform.

The UAW recognizes that Congress is now embarking on a process of considering health care reform legislation. We look forward to working with you, Mr. Chairman, and with the other members of this subcommittee as you take on this difficult, but I assure you, rewarding challenge. Thank you very much.

[The prepared statement of Owen Bieber follows:]

SUMMARY STATEMENT OF
OWEN BIEBER
PRESIDENT, UAW

The UAW strongly supports President Clinton's health care reform proposal. In our judgment, it would address the problems of declining access to care, escalating costs, and inadequate quality of care in a manner which would be good for workers, employers and the entire country.

The Clinton health care proposal contains a number of basic principles which the UAW has long supported. Specifically, it would:

- guarantee comprehensive health care benefits to all Americans;
- contain escalating health care costs through enforceable budgets;
- establish a level playing field for employers and families by requiring all employers to contribute to the cost of health care for their employees, and by requiring health care plans to abide by community rating in setting the premiums for health insurance coverage;
- assure coverage for early retirees, while addressing the competitive problems associated with financing health care benefits for this vulnerable group;
- limit the premiums and cost sharing which families are required to pay for health care;
- preserve the existing preferential tax treatment for most health care benefits;
- assist senior citizens by adding prescription drug coverage to Medicare and by establishing a new long term care program to provide home and community based care for disabled individuals;
- improve the quality of care received by individuals by disseminating information on health outcomes, and by expanding the choice of physicians and other health care providers for many Americans; and
- move towards our long term goal of a single, unified health care system by requiring most families and employers to obtain their coverage through regional "health alliances", and by allowing the states to establish single payer systems.

The UAW strongly opposes the alternative proposals which have been advanced by Senator Chafee and Representative Thomas, as well as by Representative Cooper and Senator Breaux. They would not guarantee universal coverage in the near future. They do not take serious steps to contain escalating costs. They would preserve the enormous waste associated with the existing multitude of private insurance carriers and would undermine the principle of community rating. And they would make major changes in the tax treatment of health care benefits that would penalize employers and workers who have comprehensive health care benefits.

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Mr. Chairman. My name is Owen Bieber. I am President of the International Union, United Automobile, Aerospace & Agricultural Implement Workers of America (UAW). On behalf of the 1.4 million active and retired members of the UAW, I would like to thank you for the opportunity to present our views on President Clinton's health care reform proposal and its impact on workers and retirees.

The problems facing the health care system in the United States have been well documented. There is now a broad consensus that prompt action must be taken to address the interrelated problems of declining access to care, escalating costs, and inadequate quality of care.

Mr. Chairman, the UAW believes that the plan presented by President Clinton would address these problems in a manner which is good for workers, good for employers and good for the entire country. The UAW strongly supports the President's proposal. We commend the President, the First Lady, and the entire White House health care team for their efforts in developing this package of reforms.

The UAW believes we now have an historic opportunity to achieve our long-held dream of a comprehensive national health care program. We urge Congress to support the President's proposal.

The health care reform proposal developed by the Administration contains a number of basic principles which the UAW has long supported. We would like to discuss each of these points.

1. Universal Coverage

The Clinton health care plan would guarantee comprehensive health care benefits to all Americans. Everyone would be entitled to this coverage regardless of income, health or employment status, age, where they reside, or other factors.

The UAW has long believed that health care should be a basic right for all Americans. We commend the President for his courage in making this principle a central component of his proposal.

The UAW is also pleased with the breadth of the benefits package which would be guaranteed under the President's proposal. Universal coverage is meaningless unless it includes the full range of health care services which are needed by families. The President's plan would provide most benefits which are now covered by major Fortune 500 companies, as well as additional preventative services. Certainly this is a far cry from so-called "catastrophic" proposals which have been floated in the past.

Although many UAW members already have comprehensive health care benefits under the collective bargaining agreements the union has negotiated with employers, our strong support for the Clinton program is not just a function of our commitment to the principle of universal coverage. Our members also have a strong stake in the achievement of this principle.

During the past decade thousands of UAW members have lost health insurance coverage after they were laid off. All too often this has happened in the context of plant closings and bankruptcies. At the same time, many UAW members have been forced to accept employer demands to cut back on health insurance coverage, including restrictions on dependent eligibility, increases in employee cost sharing and reductions in the coverage of specific benefits. And, especially since FASB promulgated its new accounting standards for post-retirement medical benefits, thousands of retired UAW members have been faced with reductions in or the outright termination of their health insurance coverage.

The Clinton health care proposal would put an end to the trauma and tragedy associated with these assaults on the health security of UAW members. Under the President's proposal, their health care coverage could never be taken away. Like all Americans, our members would gain the

security of knowing that their health care benefits will always be there when they are needed.

2. Cost Containment Through Enforceable Budgets

The Clinton health care plan would contain escalating health care costs through a number of mechanisms. The formation of large purchasing pools (the health alliances) would enable consumers to negotiate better rates with health care providers. Guaranteeing all families a choice of health care plans will force the plans to compete with each other by holding down costs while maintaining quality. And the standardization of claims forms and the reduction of micromanagement will help to eliminate a lot of the wasteful administrative expenses associated with our current system.

Most importantly, however, the Clinton plan would establish a "back-stop" national health care budget that would gradually reduce the rate of growth in health care costs, both in the private sector and under Medicare and Medicaid. In the private sector this budget would be enforced by capping the increase in premiums charged by health care plans. In the public sector this budget would be enforced by directly limiting federal expenditures under Medicare and Medicaid.

The UAW strongly supports the principle of enforceable health care budgets. We believe this is the only way to prevent health care costs from continuing to spiral out of control.

Throughout the last decade, escalating health care costs have strained the resources of families, businesses, and the federal and state governments. Tough cost containment measures are not only an essential prerequisite for overall health care reform. They are also essential to free up the necessary resources for other unmet social needs.

Despite the general consensus in support of cost containment, the notion of imposing overall budget discipline on the health care sector remains controversial. But common sense tells us that health care costs will never be brought under control if we continue to give the health care sector a blank check. Individuals, businesses, and the federal and state governments all use budgets to control their spending in other areas. If we can develop budgets to circumscribe spending in such complex and vital areas as national defense, surely it makes sense to use the same approach with respect to spending on health care.

Unless our nation adopts a health care budget, we will never establish the discipline which is needed to force

health care plans and providers to seeks ways of delivering quality care in a more efficient manner. Without budget discipline, plans and providers can always spend more to deliver the federal package of benefits; there will not be any incentive for them to seek ways to provide those benefits for less.

I want to stress, however, that the UAW's support for the imposition of budget limits on Medicare and Medicaid is contingent on the imposition of similar restraints on private sector health costs. Limitations just on public health care programs, as has been proposed by Senator Chafee, would be unacceptable to the UAW because this would inevitably lead to additional cost shifting from the public programs to the private sector, and because this could undermine the quality of care provided under the public programs by further discouraging providers from participating in those programs. I also want to caution that any limitations on spending under Medicare and Medicaid must be accompanied by provisions that will assure access to quality care for persons covered under these programs.

3. Level Playing Field: Employer Mandate and Community Rating

The Clinton health plan would establish a level playing field with respect to the payment of health insurance premiums by requiring all companies to contribute to the cost of health care for their employees, and by requiring health care plans to abide by community rating in setting the premiums which are charged to companies and families for health insurance coverage. The UAW applauds the Administration for including this principle in its proposal. We believe the establishment of a "level playing field" would provide several important benefits.

First, it would eliminate the cost shifting between employers which currently takes place in our health care system. Employers that currently provide health insurance coverage to their workers would no longer have to subsidize employers that fail to provide such coverage. There would no longer be any "free riders". Instead, all employers would be required to pay their fair share.

Second, it would eliminate differentials in health care costs for families and employers based on health status or age. Employers and families would no longer be penalized just because one of their workers or members happens to

develop a serious medical condition that requires expensive treatment. And they would no longer be penalized simply because they have older workers or members. Instead, the higher costs associated with sick or older persons would be spread broadly throughout society, with everyone sharing the burden of these higher-cost individuals.

Many of the companies with whom the UAW negotiates, including the Big Three automakers, are currently penalized because of the absence of a "level playing field". It is estimated that 15 percent of the Big Three's health care costs are attributable to cost shifting associated with the spouses of auto workers who are employed at other companies but do not have insurance coverage through their own employer. The Big Three automakers also have to shoulder health care costs attributable to persons who are currently uninsured. In addition, the Big Three automakers have higher health care costs because their workforce is generally older. As a result of all of these factors, the Big Three automakers and other manufacturing companies are placed at a significant competitive disadvantage with other employers. This creates tremendous pressure to cut back on health insurance coverage and has a negative impact on employment.

The Clinton health plan would eliminate these problems by establishing a level playing field for all employers and

families. As a result, high risk individuals would no longer be penalized. And employers would no longer be forced to compete on the basis of their health care costs. They would not have to choose between cutting health care benefits or losing jobs.

The UAW believes as a basic principle that employers should not be forced to compete on the basis of their health care costs. And there should not be any discrimination between families based on health costs. Instead, there should be a level playing field, with all employers and families being required to contribute their fair share. Our country currently provides a basic level of retirement income to all individuals through the Social Security system, which is financed through equal contributions by all employers and workers (i.e. the same percentage of payroll). The same principle should be applied to financing health insurance coverage for all Americans.

The UAW is concerned that under the Clinton plan the level playing field is phased in too slowly for large employers (those with more than 5000 that decide to opt into the regional alliances). Specifically, the benefits of community rating and the 7.9 percent of payroll cap on employer liability for health insurance premiums are only gradually phased in over eight years, with no benefits being provided for the first four years. The UAW urges Congress

to consider a quicker phase in, without any abrupt "cliff" after four years.

4. Retiree Health Care

The UAW strongly supports the provisions in the Clinton health plan dealing with early retirees between the ages of 55 and 65. We view this as one of the most critically important components of the President's plan.

Millions of early retirees do not have any employer-paid health insurance coverage. These early retirees are forced to rely on expensive individual policies, or else are left without any coverage. About two million early retirees currently do have employer paid health insurance coverage. But the security of this coverage has increasingly come under attack.

During the past decade, the UAW has witnessed dozens of cases where employers have abruptly cancelled or reduced health insurance coverage for retirees and their families. The impact of these cutbacks has been devastating, particularly for early retirees who do not have Medicare to fall back on. Often these early retirees cannot get replacement coverage because they are considered "uninsurable" by private insurance carriers. Even when individual policies are available, the cost is often

prohibitive. Many of these individuals made their decision to retire based on the promise of continued health insurance coverage. When that promise is suddenly broken, it is too late for the retirees to start over again. As a result, their legitimate retirement expectations are dashed, and they are forced to live with a drastically reduced standard of living.

The UAW's experience with cutbacks in retiree health coverage is not unique. The same pattern has been repeated in countless situations across this country during the last decade.

A number of factors have been leading more and more employers to eliminate or reduce health insurance coverage for retirees. The continuing escalation of health care costs is certainly one important factor. In addition, many of the companies that provide retiree health insurance coverage - particularly older companies in the manufacturing sector - have been encountering growing competitive pressures to cut back on coverage for retirees. These employers face competition from foreign companies which operate under national health care programs that do a much better jobs of containing health care costs, and distribute the burden of retiree health care costs across the entire society. These employers also face competition from younger, domestic companies which have a much lower ratio of

retirees to active workers, and therefore do not have to bear the same burden of retiree health care costs.

Health care costs for employers in Japan are approximately one-third the costs for employers in this country. This gives the Japanese auto companies a big cost advantage when they import cars into this country. In addition, the transplant facilities established by the Japanese companies in this country are relatively new. They have very few retirees. In contrast, the domestic auto companies have almost as many retirees as active workers. This factor gives the Japanese transplant facilitates a considerable cost advantage over the domestic companies. A study by the University of Michigan Transportation Research Institute estimated that the Japanese transplant facilities have a $600 per car cost advantage over the Big Three automakers attributable solely to differences in health care costs, the biggest portion of which is due to differences in retiree health care costs.

The accounting standards which were recently promulgated by FASB for post-retirement medical benefits have aggravated the competitive problems posed by retiree health insurance coverage. This accounting standard requires companies to recognize retiree health liabilities for current and future retirees on their financial statements. General Motors announced a one-time FASB charge

of 20.8 billion in 1992; Ford reported a one-time charge of $7.5 billion; and Chrysler reported a one-time charge of 4.7 billion. Equally alarming, the Big Three automakers will each have to report substantially increased charges for retire health care benefits each year, over and above the cash outlay for these benefits that was previously reported. For GM, this additional charge is about $1.4 billion. By comparison, even in its best years GM only made a profit of about $3 billion. Thus, the FASB retiree health standard will have a major negative impact on the Big Three automakers. This was demonstrated when GM's securities were downgraded shortly after it announced its FASB charge for 1992.

It is important to recognize, however, that the Big Three automakers are not the only ones who have been struggling with retiree health care liabilities. Similar dynamics are at work in other major industries, including agricultural implements, steel, mining, telecommunications, and airlines. In addition, many state and local governments have been encountering growing problems sustaining health care liabilities for retirees. And many Taft Hartley health and welfare funds also face this same problem.

The Clinton health plan would address the problems associated with providing health care to early retirees in

several ways. Most importantly, it would guarantee health insurance coverage for early retirees, just like the rest of Americans. Thus, early retirees who currently have coverage would no longer have to fear cutbacks or the outright termination of their health care benefits. And retirees who currently do not have coverage would be provided the same package of federally guaranteed benefits. Thus, all early retirees would stand to gain from the Clinton plan.

At the same time, the Clinton plan would provide for equitable financing of this coverage for early retirees, by spreading these costs uniformly throughout society. Older companies that happen to have larger numbers of early retirees would no longer be placed at a competitive disadvantage. Newer companies with no retirees would no longer be given a "free ride". Under the existing Medicare program, the costs of providing coverage to post-65 retirees are spread uniformly throughout society. The Clinton plan would simply expand this eminently fair approach to pre-65 retirees.

The early retiree provisions in the Clinton health care plan do not represent a "bail out" or undeserved "windfall" for those companies which have provided retiree health insurance coverage in the past. Rather, these provisions simply represent another example of the Administration's commitment to the principle that there

should be a "level playing field" between all employers, so that companies are not forced to compete on the basis of health care costs.

In our view, it is just as inappropriate to compel companies to compete on the basis of retiree health care costs, as it is to require them to compete on the basis of health care costs for active workers. If all employers should be required to contribute to the cost of providing coverage for active workers, and should be required to share equally the costs of providing coverage for sick or older workers, then it also makes sense to require all employers to share equally the costs of providing coverage for retired workers and their families.

Unless this principle is adopted with respect to retiree health insurance coverage, as well as coverage for the active workforce, there will continue to be significant retrenchment and job loss in certain key manufacturing industries. Many of the companies with large retiree health liabilities are facing declining market share, resulting in lower production and employment. This in turn can create a vicious cycle. As these companies downsize, the ratio of retirees to active workers increases. The FASB problem and competitive disadvantage become worse. There is a further decline in market share, followed by more cutbacks in production and additional job loss. In the

end, companies may have to file for bankruptcy, or may even be forced entirely out of business.

The recent problems at Navistar provide a clear example of this potential danger. Navistar has three retirees for every active worker. Last year it became apparent that the survival of the company and the jobs of the 7,500 active UAW employees (and 11,000 total employees) were threatened by the size of the company's retiree health liability. After painstaking, difficult negotiations, the UAW was successful in reaching a solution with Navistar which allows the company to continue in business, while protecting a modified level of retiree health benefits. Make no mistake, however, these negotiations required serious changes and sacrifices for UAW Navistar active workers and for all Navistar retirees.

Thus, in addition to assuring the security of health care benefits for early retirees, the provisions in the Clinton health care plan also will play an important role in restoring the competitiveness of many important sectors of the American economy. This not only will preserve existing jobs; it also will provide the basis for renewed economic growth that can generate new jobs in the future.

5. Limits on Family Costs

The Clinton health plan would place limits on the premiums and cost sharing which families are required to pay for health care. Specifically, families would be guaranteed that the family share of premiums for the federally guaranteed package of benefits can never exceed 3.9 percent of wages. In addition, the premiums would be subsidized for workers below 150 percent of the poverty line, and for unemployed individuals below 250 percent of the poverty line.

Furthermore, regardless of what type of plan a family enrolls in (i.e. an HMO, PPO, or fee-for-service plan), out-of-pocket costs for deductibles and copayments will be capped at $1500 for an individual and $3000 for a family. Cost sharing requirements under HMOs and PPOs will be kept very low (generally $10 per visit for outpatient services). And there will not be any cost sharing requirements for preventative health care services.

To stop health care providers from circumventing cost containment mechanisms, the Clinton plan also would prohibit balance billing by providers. This will protect families against additional, hidden charges.

The UAW strongly supports all of these features in the Clinton plan. Together they will help to provide genuine health security for American families. Persons will no longer have to live in fear that they could lose their life's savings and their home as a result of catastrophic medical expenses. And they will no longer be deterred from seeking needed medical services because of excessive out-of-pocket costs.

The UAW urges the Administration and Congress to consider lowering the cap on family premiums from 3.9 to 2 percent of wages and to extend this cap to all premiums which may be owed by a family. We believe this would provide more complete protection for low and moderate income families.

The UAW is troubled by the addition of an overall ceiling on the cost of the subsidies for families. We urge Congress to eliminate this ceiling, in order to guarantee that sufficient assistance will be made available to limit premiums and cost sharing requirements for families.

6. Tax Cap

The Clinton health plan would preserve the existing preferential tax treatment for all health care benefits that would be covered under the federally guaranteed package.

Workers would not be required to pay taxes on these benefits, and employers could continue to deduct the cost of their premium payments for these benefits.

In addition, the Clinton plan would continue this same preferential tax treatment for any employer payments for the family share of premiums for the federal package of benefits, and for any cost sharing requirements (i.e. copayments and deductibles) under that federal package.

In situations where employers are currently providing benefits beyond the federal standard, the Clinton plan would "grandfather" the tax free status of these benefits for a period of ten years. After that time, workers would have to pay tax on the value of these benefits (but employers could continue to deduct the cost of these benefits as a business expense). However, since the federal benefit package under the Clinton plan is comprehensive, very few benefits would eventually be subject to taxation.

The UAW believes as a matter of principle that workers should not be required to pay taxes on their health care benefits. We commend the Administration for preserving the tax free status of most benefits. In rejecting suggestions that they should support a tougher "tax cap" on health care benefits, the First Lady has forcefully expressed the view that it would be wrong to subject 35

million Americans to a substantial tax increase. The UAW wholeheartedly concurs with this assessment.

The taxation of health care benefits would result in a large tax on the middle class. It also would lead to a reduction in important health insurance coverage. And it would not be an effective mechanism for slowing the growth in health care costs. For these reasons, the UAW continues to oppose the various proposals which have been advanced to alter the current tax treatment of health care benefits.

7. Senior Citizens

The Clinton health plan contains two provisions of particular importance to post-65 senior citizens. First, it would expand Medicare to cover outpatient prescription drugs (similar to the benefits which would be provided to the under 65 population). Second, it would establish a new long term care program to provide home and community based care for disabled individuals.

The UAW strongly supports both of these initiatives. We have long supported the expansion of Medicare to cover prescription drugs. Senior citizens currently are forced to spend an ever increasing portion of their income to obtain this essential coverage. Often they must make

difficult decisions between spending money for prescription drugs that will keep them healthy or using their scare resources to buy food, clothing and other necessities. By expanding Medicare to cover prescription drugs, we can put an end to this terrible situation and assure that all senior citizens have access to this important protection.

It is also worth noting that this provision will help to reduce the retiree health insurance liabilities of many major employers, especially older manufacturing companies that typically provide this coverage to their post-65 retirees. This in turn will help alleviate the FASB and competitive problems facing many of these companies, and thereby help to generate greater economic growth.

The UAW also has long been on record calling for a comprehensive long term care program. We view the Clinton proposal as an important first step in that direction. It addresses the most pressing need for expanded home and community based services that will allow disabled individuals to remain at home as long as possible. These services help to preserve the dignity of disabled individuals. And they have been proven to be more cost effective than custodial care.

8. Regional Alliances

The Clinton health plan would require the states to establish one or more regional alliances which would act as "purchasing cooperatives" for health insurance coverage. Most families would receive their coverage through these regional alliances.

The UAW believes this aspect of the Clinton health plan represents a positive step towards the ultimate goal of a single, unified health care system. Requiring most individuals to receive their coverage through regional alliances will produce several important benefits. It will give the alliances sufficient bargaining power to be able to negotiate better rates with health care providers, and to thereby hold down health care costs. It will help to reduce administrative waste. And it will help to preserve the principle of community rating, so that all employers and families share equally in the costs of providing coverage to sick and older persons.

The UAW opposes the provision in the Clinton health plan that would allow employers with more than 5000 workers to opt out of the regional alliances. And we are strongly opposed to the proposals which have been advanced by some persons to lower the threshold for employer opt outs to 500 or 100 workers. This would weaken the bargaining power of the alliances. It would increase administrative

complexity and waste. And it would undermine the principle of community rating.

Employers with lower cost workforces (because they are healthier or younger) will decide to opt out, so they can get the benefit of their lower experience rates. The alliances will then be left with older, sicker workers. As costs begin to spiral upwards, there inevitably will be pressures to cut back on benefits. In the end, we will be left with a two tier health care system. Employers and their workers who have opted out of the alliances will receive comprehensive benefits and excellent quality of care. Those companies and workers who are left behind in the alliances will be forced to accept substandard benefits and inferior quality of care.

To prevent the alliances from becoming the dumping ground for bad risks and the resulting establishment of a two tier system of health care, the alliances must be made as broad as possible. The UAW believes that no employers should be allowed to opt out. Instead, there should be a single system which encompasses everyone. At a minimum, however, there must not be any retreat from the 5000 threshold contained in the Clinton health plan.

9. Single Payer Option

The Clinton plan would allow the states to establish single payer systems. This means there could be just a single alliance or other payer within the state. In addition, it means that the states could decide to have the single payer directly establish the reimbursement rates for health care providers (through global budgets for hospitals and fee schedules for physicians and other providers).

The UAW has long supported the single payer approach to national health care reform. For this reason, we have endorsed the single payer proposal set forth in the Wellstone-McDermott bill (S. 491; H.R. 1300). We continue to believe that this approach represents the best means of guaranteeing universal coverage, containing escalating costs, and assuring high quality of care.

The UAW supports the Clinton health plan because, in our judgment, it is consistent with many of the important principles embodied in the single payer approach to national health care reform. It would guarantee comprehensive health insurance coverage to all Americans regardless of health or employments status. It would contain escalating health costs through enforceable budgets. It would establish a level playing field between employers and address the problems associated with retiree health care benefits. It would place limits on the premiums and cost sharing which families are required to pay for health care services. And

would preserve the preferential tax treatment for health e benefits.

In addition, by expressly allowing the states to ablish single payer systems, we believe the Clinton plan d provide the basis for gradually moving to a national gle payer system. Thus, the UAW believes it is tically important that the state single payer option be ained in the Clinton health plan.

Quality of Care

The Clinton health plan contains a number of features gned to guarantee high quality of care. First, and aps most importantly, the Administration's proposal d significantly expand the choice of physicians and r health care providers for many Americans. At the ent time, individuals are generally limited to the th care plans offered by their employers. In recent s, employers have increasingly limited the choice of is available to workers in an effort to contain rising s. Thus, many workers have found their choice of viders severely restricted.

The Clinton plan would expand the choice of providers allowing families to enroll in any of the health care ns offered under their regional alliance. And in those

situations where large employers have opted out of the regional alliances, these companies would still be required to give their workers a choice of at least three health care plans, including a fee-for-service plan. Thus, no employer would be able to insist that all of its workers and their families must be enrolled in an HMO or PPO. The choice will be left where it rightfully belongs, with the workers and their families.

The UAW is also pleased that the Clinton plan includes provisions to increase spending on public health programs that will ensure adequate access for undeserved areas and populations. This is essential for both rural areas and our inner cities.

The UAW fully supports the provisions in the Clinton plan that would require health alliances to disseminate information to consumers on the quality of health plans. And we welcome the provisions requiring practice guidelines and performance feedback for health care providers.

The UAW also supports the provisions in the Clinton health plan that would:

* establish an ombudsman to assist consumers;

* assure the privacy of health records;

* establish limits on attorneys fees in malpractice cases; and

* increase the numbers of family and general practitioners, and reduce the numbers of medical specialists.

We believe these measures would all contribute to the delivery of high quality health care.

Competing Proposals

A number of proposals have already been advanced in Congress as alternatives to the Clinton health plan. In addition to the Wellstone-McDermott bill, there are two other major alternatives: the Chafee-Thomas bill (S. 1770; H.R. 3704) and the Cooper-Breaux bill (H.R. 3225; S. 1579). The UAW strongly opposes both of these measures. In our judgment, they would not solve the serious problems confronting our health care system. Instead, they are thinly disguised attempts to maintain the status quo.

The Chafee-Thomas and Cooper-Breaux proposals would not guarantee universal coverage in the near future. The Chafee-Thomas proposal asserts that all individuals would eventually be required to have health insurance coverage,

but admits that this is a distant goal that would only gradually be achieved at some distant date. The Cooper-Breaux bill never even purports to guarantee universal coverage. It allows all individuals to buy health insurance through purchasing cooperatives, but does not provide any financing mechanisms to make coverage affordable for all Americans. As a result, CBO estimated that this approach would leave 25 million Americans without health insurance coverage.

The UAW believes this is unacceptable. To be meaningful, health care reform must achieve the goal of universal coverage in the near future. The Chafee-Thomas and Cooper-Breaux proposals fail to meet this challenge because they do not step up to the hard decisions on how to finance universal coverage. They both reject the notion of an employer mandate. But this inevitably leads to two choices: either taxes must be raised to provide coverage to the uninsured, or else the goal of universal coverage must be abandoned. Regrettably, the Chafee-Thomas and Cooper-Breaux proposals opt for the second alternative.

It is worth noting that the adamant opposition to an employer mandate which forms the basis for the Chafee-Thomas and Cooper-Breaux proposals is inconsistent with the theory of "managed competition" which they purport to embrace. The father of "managed competition", Alain Enthoven, and

the Jackson Hole Group have long supported the concept of an employer mandate. They have recognized that this is necessary to prevent employers from "dumping" their workers onto public programs which subsidize health care for the uninsured. The fact is, without an employer mandate "managed competition" cannot work. Either government costs for subsidies will sky rocket or else large numbers of persons will remain uninsured.

The Chafee-Thomas and Cooper-Breaux proposals also fail to take serious steps to contain escalating health care costs. In particular, they do not include any provisions for enforceable budgets to restrain the growth in health care expenditures. Despite all of their rhetoric about fostering competition between health plans, achieving administrative savings, and reforming our malpractice laws, the fact is the Chafee-Thomas and Cooper-Breaux proposals avoid the tough measures which are necessary to bring costs under control. Without an overall budgeting mechanism, there is no guarantee that health care costs will be controlled. In effect, the health care industry will continue to have a blank check from the government and the American people.

It is likely that the Chafee-Thomas and Cooper-Breaux proposals would actually aggravate the escalation of health care costs. Because they would both provide subsidies to

h over low income individuals, they would both increase
ov l expenditures on health care. But since they do not
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nc g to prevent costs from skyrocketing. In effect, the
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t. ice of the cheapest plan in the region. These two
a ches are really just two different sides of the same
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w s and employers to cut back on health care coverage.
Th n turn would shift enormous costs to families. But it
wc not do anything to contain escalating costs.

It is important to note that the Chafee-Thomas proposal would impose a sizeable tax increase on middle class families. Approximately 35 million Americans would be hit by this new tax. The additional tax liability could mount to hundreds of dollars for a typical family. During the recent debate over the budget reconciliation legislation, many Republicans spoke at length about the evils of tax increases that were primarily directed at wealthy individuals. It is indeed ironic that some of these same Republicans are now supporting the Chafee-Thomas health care proposal, whose central component is a substantial tax increase on the middle class.

Finally, the Chafee-Thomas and Cooper-Breaux proposals would not require most employers to join regional purchasing alliances. This is justified on the basis that they do not want to create new bureaucracies and or a so-called "one-size fits all" mentality. When one looks behind this lofty rhetoric, however, it becomes apparent that the approach embodied in the Chafee-Thomas and Cooper-Breaux proposals would have two major impacts. First, it would preserve the existing multitude of private insurance carriers. This in turn would continue the exorbitant levels of administrative waste associated with the current system. One study has shown that private insurance carriers spend 36.4 cents on administration, marketing and overhead for every dollar they spend on claims, compared to

only 2.1 cents for Medicare. Thus, the Chafee-Thomas and Cooper-Breaux proposals actually preserve wasteful bureaucracy, not prevent it.

Second, the approach adopted by the Chafee-Thomas and Cooper-Breaux proposals would quickly undermine the principle of community rating. Employers with younger, healthier workers would decide to opt out and provide coverage on their own. The purchasing alliances would soon become the dumping grounds for sicker, older workers. As the costs in the alliances spiral upwards due to adverse selection, there will inevitably be demands to cut back on benefits. The end result will be a two tier health care system. Employers and workers outside of the alliances will be able to receive comprehensive, quality health care services, whereas those that remain in the alliances will be forced to accept reduced benefits and substandard quality of care.

Conclusion

In conclusion, Mr. Chairman, the UAW appreciates the opportunity to testify before this Committee on the subject of President Clinton's health care reform proposal and its impact on workers and retirees. The UAW strongly supports the President's proposal. We believe it embodies a number

of principles which are necessary to provide genuine health care reform.

The UAW recognizes that Congress is now embarking on a long process of considering health care reform legislation. We look forward to working with you, Mr. Chairman, and with the other Members of this Subcommittee, as you take on this difficult but rewarding challenge. Thank you.

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Chairman WILLIAMS. Thank you, Mr. Bieber.

Mr. Sweeney, President Sweeney, thank you very much for accepting our invitation to be with us. Please proceed.

Mr. SWEENEY. Thank you, Mr. Chairman. My name is John Sweeney and I'm the president of the Service Employees International Union. With over one million members in the service sector, SEIU is the largest union representing service workers in the United States.

On their behalf, I would like to thank Chairman Williams and all of the other members of the subcommittee for the opportunity to present our views on the Health Security Act.

In his State of the Union address last week, President Clinton stood tall against the opponents of reform and said that he would veto any health care reform legislation that did not include universal coverage. The members of SEIU could not agree more. It is time to put an end to partisan bickering and provide all Americans with the security of health insurance that can never be taken away.

We support the President's comprehensive plan because it meets all of our principles for reform. The plan calls for universal coverage for all Americans regardless of health or employment status, provides comprehensive benefits, real cost control, quality improvements, fair and equitable financing, and protections for health workers. These are the criteria that we used to judge the various health care reform proposals that have been put forward.

An important aspect of President Clinton's plan is that it requires all employers to contribute to their workers' health insurance coverage. The strength of the employer mandate approach is that it builds on the existing system and would reach the vast majority of the uninsured. Among the 39 million Americans who lack insurance, 85 percent belong to families that include an employed adult.

An employer mandate will also reduce costs for the majority of employers who are already providing health insurance. Many of them are paying more than their fair share because they are covering the working spouse of their employees as well as paying extra to cover the uninsured. In essence, they are subsidizing their competition.

Firms that do provide health benefits are increasingly finding themselves at a competitive disadvantage. For example, SEIU Local 750, which represents building service workers in Orlando, Florida, reports that one of its contractors lost a contract with Delta Airlines that it had held for eight years to a non-union contractor. The non-union contractor did not provide health insurance for its workers and was able to underbid the unionized contractor.

In addition to the employer mandate, the Clinton plan will control costs by placing a cap on employer premium contributions of 7.9 percent of payroll. In the interest of parity, we believe that this same protection should be extended to public employers as well.

The Health Security Act will also encourage firms to take the high road to competitiveness by improving productivity and investing in their workers, rather than the low road of wage and benefit cutbacks.

Health care workers support systemic health reform that puts the patient's needs at the center and strives to eliminate the ineffi-

ciencies that have contributed to rapidly rising costs. The HSA recognizes challenges facing front-line health care workers and establishes a number of programs designed to help them meet those challenges, including training and career ladder programs.

Thank you, Mr. Chairman. I am happy to be here and happy to answer any questions.

[The prepared statement of John J. Sweeney follows:]

TESTIMONY OF
JOHN J. SWEENEY

My name is John J. Sweeney and I am president of the Service Employees International Union. After 50 years of struggle, we are on the verge of bringing much needed reform to our nation's health care system. We applaud the President and Mrs. Clinton for tackling this issue, and I am pleased to be invited to testify before this subcommittee on our views on the President's proposal. The one million SEIU members who work in both the public and private sectors support comprehensive health reform. On their behalf, I would like to thank Chairman Williams and the other members of the subcommittee for this opportunity to testify today.

Our members don't need charts and graphs or expert pronouncements to understand that there is a crisis in our health care system. Our members have fought hard to hold on to their health insurance, often foregoing wage increases and improvements in other benefits to maintain coverage for, themselves and their families. They have faced greater out-of-pocket costs and declining choices as employers have tried to restrict where and when they can see their family doctors.

While disagreements over health care issues have made collective bargaining more contentious than it otherwise would have been, labor and management have also worked together to pioneer new cost containment strategies such as utilization review and managed care. While these measures showed some short-term success, they were unable to blunt the long-term rise in costs. Only system-wide reform can provide the relief that workers and their employers need.

We support the President's comprehensive plan because it meets all of the SEIU principles for reforming the current system. The plan calls for universal health coverage for all Americans regardless of health or employment status, comprehensive benefits, real cost control, quality improvement, fair and equitable financing, and protections for health workers. These are the criteria by which we judge the various health care reform proposals that have been put forward.

SEIU is opposed to the Managed Competition Act of 1993 (H.R. 3222) and proposals offered by Representative Michel and others because they do not meet SEIU's principles for reforming the health care system. These alternative bills are not merely painless placebos. They would actually make things worse for middle-class families. What they all have in common is both new taxes on employer-paid health benefits and total reliance on market forces to drive down costs.

President Clinton's reform proposal would dramatically improve the economic situation of workers, their families and the businesses for whom they work. The proposal would also alleviate pressure on state and federal government budgets which are being severely strained by the rapidly rising cost of public health care programs.

Universal Coverage: No Compromise

It should be a source of shame to us that in the richest nation on earth there are 39 million people without any form of health insurance whatsoever. Millions more are underinsured and often do not discover the crucial gaps in their coverage until it is too late. In addition to the high cost of health insurance, many individuals and families lack access to coverage because their employer does not provide it or because of pre-existing conditions that the insurance company refuses to cover.

President Clinton's plan would eliminate existing barriers to coverage and guarantee every American access to a comprehensive range of health care benefits. No one would be denied coverage because of his or her income, health or employment status. H.R. 3222 clearly violates the principle of universality, leaving millions of Americans without health security.

Universal coverage is also an important element in cost containment. Uninsured persons still seek care, often through very costly and inefficient mechanisms. These costs are passed on by providers to their paying customers, the insured population.

President Clinton's proposal will also give the majority of insured Americans a far greater range of provider and plan choices than they have now. Under the current system, employers choose what plans are available to their workers. As costs have risen, employers have sought to restrict choice. Under the Clinton plan, workers will be able to choose from among any qualified health care plans in their region.

The Need for an Employer Mandate

If we can agree that universal coverage is an imperative, the question becomes how to provide it. Short of a totally tax-financed system, an employer mandate would appear to be the best way to pay for universal coverage. The strength of an employer mandate approach is that it builds on the existing system. Nearly two-thirds of the non-elderly have employment-based coverage. Among the 39 million Americans who lack insurance, 85 percent are members of families that include an employed adult. A system that required all employers to contribute to the cost of health insurance for their workers would reach the vast majority of the uninsured.

An employer mandate would bring an end to the cost-shifting from employers who don't provide health protection to their employees to those that do. Many employers who are currently providing insurance are paying more than their fair share because they are paying to cover the uninsured and paying to provide coverage to the working spouses of their employees. In essence, they are subsidizing their competition. A 1991 National Association of Manufacturers study found that the cost of providing coverage to working dependents increases costs for firms providing insurance by 20 percent.

Firms that do provide health benefits are increasingly finding themselves at a competitive disadvantage. For example, SEIU Local 750 represents building service workers in Orlando, Florida. One of the contractors whose employees Local 750 represented lost a contract with Delta Airlines that it had held for over eight years to a nonunion contractor. The nonunion contractor did not provide health insurance for its workers, and thus was able to underbid the unionized contractor.

The growing disparity in labor costs between firms that do provide insurance and those that don't is also beginning to generate serious distortions in the labor market. The dramatic increase in the number of part-time and contingent employees, which constitute half of all new jobs created during the past year, is being driven in large part by the desire of employers to avoid the cost of health care benefits.

By requiring all employers to contribute to the cost of providing health insurance to their workers, the Health Security Act will eliminate the incentive to hire part-time, temporary, or contract workers simply to avoid paying for health care coverage. The plan, however, is not biased against part-time employment since premiums are pro-rated for part-time workers.

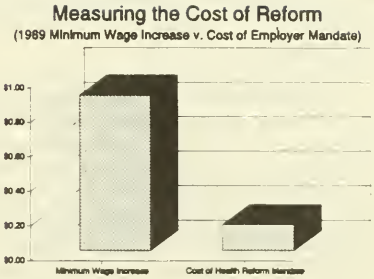
It is often alleged that an employer mandate will result in job loss. Two commonly cited studies, by the Employment Policies Institute and the CONSAD Research Corporation, make several fundamental errors in characterizing the Health Security Act. They completely exclude from their analysis the discounts to small and low-wage businesses that the plan provides; they use a benefit package that is far more expensive than that included in the Act; and their assumptions about how firms change their employment in response to cost changes is at least three to six times higher than most conventional estimates.

Real world evidence suggests that mandates do not have a major impact on employment. Hawaii imposed an employer health insurance mandate in 1974. Since then, private non-farm employment in Hawaii increased by 90 percent, compared to 54 percent in the United States as a whole. Employment in retail and wholesale trade, which in theory would have been especially vulnerable to the mandate because of the large number of minimum wage workers, actually grew faster in Hawaii than in the United States as a whole.

Moreover, most observers agree that, with respect to low-wage workers, mandatory employer health insurance is tantamount to an increase in the minimum wage. Recent studies about the impact of increasing the minimum wage have shown no significant employment effects from raising the minimum wage.

For the smallest firms employing minimum wage workers, the cost imposed by the Health Security Act will be no more than 15 cents per hour, significantly lower than the 90 cent per hour increase in the minimum wage signed into law by President Bush in 1989. For larger firms with such workers, the cost would be no more than 35 cents per hour.

Given the overwhelming evidence that an employer mandate will have a minimal impact on employment, one can only conclude that the mandate's opponents must be motivated by partisanship and ideology. Their arguments have no basis in fact.



Instead of wasting time arguing over the presumed job loss that will result from an employer mandate, we should instead turn our attention to the job losses that have, and will continue to occur, if we fail to enact comprehensive health reform. A 1992 study by the University of North Carolina School of Public Health found that our failure to control health care costs over the last decade resulted in one million fewer jobs being created.

One final point on the issue of mandates. Although SEIU supports an employer mandate, we are strongly opposed to "individual mandates," which would shift the responsibility for providing health coverage from employers to families. Many employers would end up dropping their health plans, forcing middle class workers to foot the bill.

It is ironic that the backers of the Managed Competition Act style themselves as supporters of "pure" managed competition, as opposed to the modified form of managed competition that is found in President Clinton's Health Security Act. The Jackson Hole Initiative, which is widely regarded as the basis for a number of Congressional managed competition proposals, *specifically includes an employer mandate*. Even the drafters of the Jackson Hole proposal understood that, short of a totally government funded plan, there is no other way to guarantee universal coverage.

Voluntary Cost Control Efforts Have Failed

As costs escalated during the 1980s, labor and management devised new managed care techniques to control utilization in a largely futile attempt to keep health care costs under control. Our members' experience is that while managed care, UR, and other innovations can produce "one time" savings, they haven't kept costs under control over the long term.

For example, about six years ago, members of SEIU Local 79, which represents building service and health care workers in Michigan, opted to switch from their indemnity plan to an HMO to save money. However, within three years, the cost of the HMO equalled that of the previous indemnity plan. In the fourth and fifth years, the cost of the

HMO was actually higher than the indemnity would have been and the workers also began to lose benefits. At the end of the fifth year, the workers dropped the HMO and went back to the original indemnity plan.

One of our locals in Pennsylvania had a similar experience. In the early 1980s, SEIU Local 668, which represents social service workers in the state, negotiated with employers over a number of cost-control provisions (second surgical opinion, pre-admission certification, generic drugs, etc.) that were instituted for most contracts. These measures were successful in holding down costs for about three or four years. By the time the contracts were up for renegotiation, however, costs had begun to rise again and employers began asking for further concessions. The next round of negotiations saw the introduction of HMO and PPO options, as well as increased premium sharing. Despite the introduction of all of these measures, costs continue to rise at the same pace.

Despite these negative experiences, I don't want to give the impression that our members have uniformly unfavorable attitudes toward HMOs and PPOs. Often, managed care allows us to preserve benefits without increasing the cost to our members. But we also recognize that, in most cases, savings from managed care plans come from the discounted rates that those plans pay to providers. Providers make up the difference by shifting those costs onto other payers with less market power. Employer-by-employer efforts to contain their own workforce costs don't work for long, as costs climb in other parts of the system. Only system-wide reform can bring costs under control and end the cost-shifting among payers.

The rapid premium increases of recent years have had profound effects that play out a few workers at a time. SEIU Local 100 represents 200 community mental health workers in Lafayette and West Bank, Louisiana. Most of these workers make about the minimum wage. Under their contract, their employer pays up to $100 per month for their health insurance. Last November, the employee contribution was raised from $20.49 a month to $54.74 a month. Most of those workers have dropped their coverage due to the increased cost.

These figures are the result of a health care system in crisis -- and are the perfect retort to those who claim that there is no health care crisis. Those who persist in saying that we don't have a health care crisis are obviously out of touch with mainstream America. Our members, and the millions of other families struggling to make ends meet, have witnessed the crisis first-hand for years.

Pure Managed Competition Approaches Won't Bring Costs Down.

The opponents of real reform, including the insurance and pharmaceutical industries, are entreating Congress to continue to place total reliance on the market. However, continued reliance on the market flies in the face of our experience over the last decade.

Reagan-era reliance on market forces brought us the highest sustained rates of medical price inflation ever.

A key assumption of market-based reform is that the creation of a more competitive climate for health insurance plans will inevitably lead to premium reductions. The experience of SEIU Local 1000, the California State Employees Association, strongly suggests that competition alone is not sufficient to contain costs.

Local 1000 members receive their health benefits through the California Public Employees Retirement System (CalPERS). For most of the 1980s, CalPERS had most of the elements that proponents of managed competition argue must be present if the system is to work. Over 20 plans, most of them HMOs, competed with each other for enrollees. The vast majority of enrollees are in managed care plans, such as HMOs or PPOs. There were significant differences in the prices charged by plans and the state government contributed a fixed amount per worker (although the amount was not tied to the lowest cost plan), so consumers had an incentive to enroll in lower cost plans.

Despite the apparent existence of a competitive market, CalPERS actually fared worse than other employers nationally in managing health care costs during the 1980s. According to Lewin-VHI, average family premiums for the nation as a whole increased 9.4 percent annually between 1982 and 1992, compared to 12.9 percent for CalPERS fee-for-service plans and 9.8 percent for CalPERS HMO plans.

Others have argued that there is a painless route to cost control: organize the market through voluntary purchasing cooperatives without mandating any employer contribution towards the cost of coverage.

However, the lack of such a mandate is almost certain to lead to adverse selection among workers in the purchasing cooperative. Those employees who are more likely to be sick will purchase coverage, while those who are relatively healthy may go without coverage. This, in turn, will raise costs for those who do choose to purchase coverage. The result could be a vicious cycle that could well destroy the purchasing cooperative as a meaningful entity. If small employers are unable to realize lower premiums as a result of their membership in the cooperative, they would be no more likely to purchase coverage for their workers than they are now.

With the help of the Robert Wood Johnson foundation, a number of states have experimented with purchasing cooperatives for small businesses that also operate on a voluntary basis. While some small employers did obtain coverage through these arrangements, even the most successful project only enrolled 17 percent of employers who previously had not offered insurance. The Arizona Health Care Group, one of the longest running projects, only succeeded in enrolling 939 small firms, for a total of 3,093 covered lives, during the first three and half years of its existence. Similar experiments in other states proved similarly disappointing.

Insurance Reforms Without Cost Control Could Make Things Worse for Businesses and Consumers

Some argue that the health care crisis is exaggerated -- all we need is to regulate the insurance market in ways that would make it easier for those without insurance to obtain it. These provisions, which are common to most health care reform bills, include prohibiting pre-existing condition exclusions and requiring insurers to community-rate instead of experience-rate.

Taken alone, these reforms would raise costs for many businesses who are currently providing insurance. Some of those businesses might choose to drop coverage, potentially creating a vicious circle that would ultimately undermine the entire health insurance market.

While insurance reforms are clearly necessary to eliminate discrimination in the health insurance market, they must be implemented in tandem with cost control provisions that ease the burden on those businesses and consumers whose costs will go up under reform. To do otherwise creates the potential for a political backlash that could undermine the entire health care reform effort.

Taxing Health Benefits Will Hurt Middle-Class Families

Again and again we hear the refrain that we can control costs and make employees more cost conscious by taxing employer-paid health benefits. Whether the tax is levied on employers or workers, it is those companies and workers with health insurance that will have to pay more -- potentially hundreds of dollars more -- to maintain their health insurance coverage.

Blaming a patient for the high cost of a hospital visit is like blaming a robbery victim for the high cost of a crime. People seek care when they are sick and rely on doctors and other health professionals to guide their treatment and to make decisions regarding their care. In all, doctors directly account for 20 percent of national health care expenditures and control another 50 percent.

In any case, as someone who has personally negotiated hundreds of contracts, I can tell you that our members are already *very* conscious of the cost of health care. Workers with family coverage now pay almost $1,000 a year on average in premiums payments alone. Premium payments are only a part of a worker's total health care bill. Workers also have to meet their deductibles, as well as foot the bill for copayments on physicians' visits, prescription drugs, and hospital stays.

The Clinton Plan will Hold Down Health Costs

SEIU strongly supports President Clinton's strategy which relies on market pressures to bring costs under control, but reinforces them with a federal regulatory backstop. If the market works as well as some claim, then the regulatory limits need never be invoked. But should the market fail, working families need a guarantee of protection against the ravages of health care inflation.

President Clinton's cost containment strategy rests on increasing the bargaining clout of consumers to negotiate better prices with consumers. However, the health alliances must be large enough to influence costs community-wide and mandatory for most groups to minimize adverse risk selection. Premium caps provide health alliances with added leverage in their negotiations with health plans.

Aside from cost control measures which will benefit both employers and workers, the plan calls for a cap on employer premium contributions of 7.9 percent of payroll -- and, in the interest of parity, the same protection should apply to public employers. Many businesses who provide health insurance to their employees currently pay more and stand to gain a windfall under the plan.

The President's proposal also calls for a lifting of the heavy burden on businesses competing in the global marketplace by subsidizing the crippling costs of early retiree health care coverage. Most of our major international competitors spread the cost of retiree coverage across their entire population. We must follow the same path if our products are to be competitively priced and our domestic productivity is to be enhanced.

Some members of Congress are suggesting that the Clinton plan is financing reform on the backs of small businesses. The truth is that the majority of small businesses already provide health care coverage to their workers and are among the biggest winners under the Clinton plan. They will benefit from large group purchasing, from the elimination of cost-shifting, and from the generous subsidies that will be made available to them.

The bottom line is that no other nation with a national health care system relies solely on the market to control health care costs. While the specific regulatory tools vary from country to country, all nations with such systems have imposed some kind of limit on the amount they spend on health care. For all of the reasons that I have outlined above, SEIU feels that the advocates of unbridled managed competition are dangerously mistaken.

Impact on Health Care Workers

Health workers are on the frontlines of the fight for universal health coverage and controlled health costs. They support systemic health reform that puts the patients' needs at the center and strives to eliminate the inefficiencies that have contributed to rapidly rising costs.

Health care reform will accelerate the industry restructuring currently underway. This massive restructuring in the healthcare sector is expected to be at least as significant as that which occurred in the steel and auto industries of the 1980s.

Unfortunately, many health care administrators are pursuing low wage "solutions" to their cost and competitiveness problems -- downsizing by cutting good jobs, replacing highly skilled workers with less skilled workers, cutting wages, and increasing the number of part-time and temporary workers. During the past year, tens of thousands of health workers have been hit with reductions in hours, wage freezes or cuts, and layoffs.

Cost control should not be achieved at the expense of health workers, but rather by investing in them and giving them the tools they need to eliminate waste and improve the quality of patient care. A major strength of the Health Security Act is that it recognizes the challenges facing frontline health workers and establishes a number of programs designed to help them meet those challenges, including training and career ladder programs. Congress should seek to strengthen investment in the health workforce and other redeployment initiatives.

Conclusion

By way of conclusion, let me reiterate that the members of the Service Employees International Union believe that the United States is engulfed in a health care crisis that threatens to leave an increasing number of our citizens without access to health care and to rob the treasury of the funds needed for other public investment. Given this situation, the members of SEIU cannot support untested theories and untried approaches.

Rather than settling for the kind of halfway measures embodied in H.R. 3222, we urge the members of this subcommittee to support the Health Security Act (H.R. 3600), which would provide America's working families with the health security they so desperately need. SEIU is committed to defending the Health Security Act against those who advocate that we move more slowly, make incremental changes, or simply endure our current situation. We are committed to working in coalition with consumers, senior citizens, businesses (large and small), community groups, and progressive providers to fight against those special interest groups defending their financial stake in the status quo.

Once again, I want to thank Chairman Williams and the other members of the subcommittee for this opportunity to testify. We look forward to working with you to make the vision of "health care that's always there" a reality for America's working families.

Chairman WILLIAMS. Thank you very much.

President McEntee, if I recall correctly, the first time you and I were together in a situation similar to today, although we were inside, it began to rain.

[Laughter.]

Chairman WILLIAMS. Do you recall that? The roof was leaking, but we just kept going. So regardless of the weather outside or inside, we are pleased you're with us today, and we hope you get through this with no rain.

Mr. MCENTEE. Thank you, Mr. Chairman. I was listening to the comments of your colleagues, and how with walking pneumonia you struggled through those hearings. And I would just like to say to the members of the committee, if you think that was tough, I was with the Chairman, we were inside a hotel and it was a major of conference of about 400 people.

As a matter of fact, it was the Capital Hilton—I'll probably be sued for this. And the gym was directly above the conference room. And as the Chairman prepared to give his speech and walked to the podium, what appeared to be water started coming out of the ceiling. And more and more water came out of the ceiling. We tried to get umbrellas for the people who were sitting in the audience. And then the lights went out.

But I will say that your Chairman not only struggled through it, he was absolutely magnificent in terms of facing that task, so I mean he can do it, whether it's walking pneumonia or raining inside a hotel.

Chairman WILLIAMS. Well, you're very kind, but I'm from Montana and we're used to tough weather, inside or out.

[Laughter.]

Mr. MCENTEE. Mr. Chairman and members of the committee, we thank you for the invitation to speak with you about the need for health care reform in the public sector, hospitals and universities.

The 1.3 million members of AFSCME have been struggling with the crisis of America's health insurance system for the past decade and even more. Every day, they see people come in to emergency rooms with no insurance at all. All too frequently, patients arrive there because they are in crisis. If they had insurance, they wouldn't be there in the first place.

The States and cities that employ AFSCME members struggle to pay for this crisis care because no one else can. You know the constant complaint of the governors about Medicaid. As those costs skyrocket out of control, they force cuts in the rest of the budget. Just last week, the new mayor of New York City, facing a $2 billion deficit, called for a cut of over 11,000 jobs from the city payroll. Medicaid costs were a major factor, along with the constantly growing costs of caring for uninsured people who can't even qualify for Medicaid. Each month across America, the number of uninsured grows by 100,000.

When AFSCME members go to the bargaining table, they face a continuing refrain: We've got to cut health insurance costs. Our union has tried every approach known. We pioneered and helped second opinion surgery programs along with New York City and Cornell University, but still the costs went up.

We push and encourage more and more of our members to go to HMOs and PPOs and everything else, but still the costs go up.

As we began to organize workers in Indiana just a few years ago, we found, to our surprise and horror, that they were forced to drop their children from their health plans just to keep up with the costs of their skyrocketing premiums. In fact, State workers had to take their entire pay raise, which was minimal, and give it to their insurance plan to meet costs.

Mr. Chairman, members of the committee, this is a crisis that is eating away at the very fabric of the American workplace. We can't solve our budget problems unless we solve the health care crisis. We can't solve our welfare problems, as the President has correctly noted, unless we solve our health care crisis.

And Mr. Chairman, now that the States are paying more for Medicaid than they are for universities, we can't solve the growing crisis of costs of higher education until we solve the health care crisis.

President Clinton has proposed one solution: universal, comprehensive health insurance for all Americans. We believe that only his plan and the McDermott-Wellstone single payer plan will meet that test. Anything less fails to solve the crisis because it leaves Americans out of the health insurance system. Until everyone is covered, we're all at risk. The costs will continue to skyrocket and we'll be right back where we started.

The President's plan makes sure that workers and their families can keep their health insurance, whether they move or they lose their job. But despite its merits, the President's plan has some problems for public sector workers.

First, public employees and their employers must be treated the same as their counterparts in the private sector. Limiting the financial obligation for providing coverage for their workers must apply to all employers, public and private, and at the same time.

If large private sector employers can make their own health insurance arrangements for their employees, public sector employers should be given the same option. There must be parity of treatment between public and private employers.

More importantly, we believe that any reform plan, no matter what it is, will most certainly result in a restructuring of the health care workforce. Our union represents over 350,000 workers in the health care delivery system, both public and private. We need and they need assurances that these workers will not be unduly burdened by the passage of this bill.

We will be working with the administration and the Congress to ensure that these workers do not lose the jobs and benefits that they have fought hard to keep and maintain. You and the members of this committee have worked long and hard to make American workers the most productive workers in the world. You have a long and proud record of success, but none of us can rest until we have delivered health security to the American people.

We in labor have tried to do the best we can. So have the leaders of business, universities, and sometimes the health care industry. We have all failed because this is indeed a national problem.

With your help and the support of the American people, we can succeed. We pledge our support, Mr. Chairman. Together we will deliver health security in 1994.

Our union thanks you for the opportunity to be here, and we'll be pleased to answer any questions.

[The prepared statement of Gerald McEntee follows:]

GERALD W. McENTEE, PRESIDENT

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must be treated the same as their private sector counterparts.

Limiting the financial obligation for providing coverage for their workers must apply to all employers -- public and private -- and at the same time. If large private sector employers can make their own health insurance arrangements for their employees, public sector employers should be given the same option. There must be parity of treatment between public and private employers.

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With your help, and the support of the American people, we can succeed. We pledge our support, Mr. Chairman. Together we will deliver health security in 1994!

Thank you, and I'd be happy to answer any questions you may have.

Chairman WILLIAMS. Thank you. Thanks to all of you. Mr. Bieber, what is your view of how the early retiree provisions in the President's proposal relate to the general matter of universal coverage?

Mr. BIEBER. Well, Mr. Chairman, I realize that there has been a great deal—let me try to answer your question in this way—a great deal of discussion with respect to the retiree provision and, as termed, early retiree provision.

I would like to point out that this is the only coverage that those people will have. They have no employer—most of them have no employer to go back to. And the President's plan is only proposing that we do the same thing for those retirees that we would do for active workers.

Mr. Chairman, I happen to come from a plant that was in business for 68 years in Grand Rapids, Michigan. I was the president of the local union there. As a matter of fact, I'm proud to say my father helped organize that plant in 1939.

We had good health insurance. Through no fault of the employees or that employer, just the change in business and the system of the big getting bigger and the small going by the wayside, that plant went out of business two years ago.

I go back to Grand Rapids, it's my home town. I have to see people who I worked with in that plant—I worked in there 11 years before I went to work for the International Union—who are good, hard workers and who now find themselves out in the street with no health insurance coverage at all because the plant went bankrupt.

We face other situations where employers made commitments to provide health care benefits for retirees, and today, using a variety of reasons—some of them may have some validity to them, sometimes it's an easy way out, those benefits are now being canceled.

I hold up a booklet here. We just put together a booklet talking about all of these things. And it makes you cry when you see these people. And I don't think it's fair to say that we should leave them out there twisting in the wind, so to speak, and not provide for them.

And I want everyone to understand here, I do not view this as some people do, that somehow this is a windfall for companies. The auto companies that I negotiate with, I've had to negotiate hard across the table for good, fair health care coverage for the workers. But the costs of those plans have been driven up by the non-insured people that Gerry and all of us talk about here.

When people have no health insurance coverage and they go into the hospital, somebody has to pay that bill. And we have to pay it because we've got insurance, and the people who buy their own insurance pay it. There is no Santa Claus.

And I want to reiterate, it would be absolutely unfair to try to cut out these retirees. They have no place else to go. Most of them have no employer. And bear in mind, it's a difficult time to find a job if you're 25 years old today; it's impossible almost if you're 55 and beyond.

Chairman WILLIAMS. Well, you and obviously your union feel strongly about the early retiree protection, so you probably have looked at the other plans, particularly on the Democratic side, the

Cooper plan; on the Republican, Chafee-Michel. Are you satisfied with the coverage that they provide for early retirees?

Mr. BIEBER. No, because it—I'm really trying to be kind when I say it's nonexistent in those plans.

Chairman WILLIAMS. You've addressed this, but I've gone over the testimony, and one of the witnesses on the next panel criticizes the early retiree provision as a concession to special interests, a costly concession to special interests.

Let me ask you the question this way, and we only have about a minute left here, Mr. Bieber. Because you've rather addressed that, let me ask it this way. Why wouldn't organized labor keep these matters on the bargaining table rather than having the public, in this instance, the Federal Government, provide what has always been a benefit that you have had to bargain for?

One of the strengths of organized labor has been your success at the bargaining table in raising the standard of living of your workers. Here is a major bargaining item, and you're supporting the public taking that away from the table. Why is that?

Mr. BIEBER. Well, I would go, first of all, to the point I already made, Mr. Chairman. It's pretty difficult for me to go back to the bargaining table at my home plant to try to take care of the problems of those retirees since that plant doesn't exist anymore. That's number one. There isn't anyone there to provide those benefits.

The cost factor—you know, we talk about competitiveness every day. This is a big—the whole insurance cost is a big competitive factor. We're in the process of downsizing I think every single facet of our society today, including the Federal Government. How would you propose that you handle this downsizing?

Remember, when older people go out of the auto industry, whatever the industry might be, you're providing jobs for younger people that would otherwise disappear. So this isn't some gravy train that you're giving them.

You ask me why are we willing to move off from an item that we negotiate. Because there is no way that you can continue to handle the problem of overall society, of the government, of the country through just a few collective bargaining tables. It becomes an overbearing cost.

Chairman WILLIAMS. Well, thank you. We'll all stay within our five-minute rule here. We have quite a number of members here that may wish to ask questions, so we will enforce the no-more-than-five-minute rule. Mrs. Roukema.

Mrs. ROUKEMA. Thank you, Mr. Chairman. I for one, let me say that you'll get no argument from me as to the need for insurance reform, and that may be the crux of the whole problem here, in the semantic question that I asked in the beginning. It may be just a matter of semantics. Whether you're calling it a health care crisis and I'm calling it an insurance crisis, we in many respects have meant the same thing on that score.

But I want to go back to the question that the Chairman has raised and then go on from there to the question of costs. I'm really a little perplexed—more than a little perplexed by the reaction of labor here.

Correct me if I'm wrong, but the way I read this proposal, or the way I understand the proposal, and the consequence of it, is that

the early retiree incentive goes into play only if the employers will drop their current corporate plans. Right? Their ERISA plans. Correct?

Chairman WILLIAMS. That's correct.

Mrs. ROUKEMA. Right? Yes, correct. And those plans generally provide more generous benefits, as I understand it, to any regional alliance proposal or Federal Government plan.

Now, it seems to me that by making this deal and this agreement on early retirees, the way it's been structured—I'm not denying that something should be done for early retirees, but the way this is constructed, it seems to me that all the incentives and the inducements there are put into place for corporate employers to abandon their plans and end up giving much reduced plans to their current employees, under the alliance program. Would that not be the——

Mr. BIEBER. I don't think that's what will happen.

Mrs. ROUKEMA. Why not?

Mr. BIEBER. Well, because I don't——

Mrs. ROUKEMA. Oh, only the part for the early retirees. All right. So they can keep it on, but then—in a step-by-step proposal? Yes. Step-by-step. All right, we've all learned something here. We have all learned something here, I think.

Let's get on to the cost factor, because this is where you have been accused, or the President has been accused of catering to special interest groups and bailing out both corporations as well as unions at the expense of others.

How do you propose that we can credibly finance this proposals with the costs that are quite enormous? Isn't that representing another cost shifting to existing employers and other employers who aren't benefiting? The costs can range anywhere from $6 billion to $12.5 billion, and others have estimated it as even higher. That's a significant cost factor that has not been accounted for in this program, and your employers are going to have to take up the slack, are they not?

Mr. BIEBER. I'm going to let my colleagues answer as well, and I don't mean to be in any way discourteous. You know, I think the President's plan is well thought out, and I think they covered how you finance it.

But if we really want to get down to talking about what is the most economical way to finance a health care plan in this country, well, then we would shift because everything that I've ever seen, and I would question anyone else seeing something different, then we would shift to what is my original position, and that is a single payer plan. That's the cheapest way to go. But I don't think we're going to enact that.

Mrs. ROUKEMA. Well, it's not cheap. There's no basis on which to say that's the cheapest way to go. But it's another way to go, it's another way to allocate costs, through general taxes.

Chairman WILLIAMS. It's the savings.

Mr. BIEBER. Yes, it's the savings under single payer. I don't want to become argumentative. I sat last week in a panel in Michigan in which Governor Engler sat on the panel, CEOs of organized and unorganized plants. Mr. Hoekstra would recognize Steel Case of Grand Rapids. Jerry Myers, the CEO, sat next to me.

It wasn't my slides that were there. As a matter of fact, they were Governor Engler's slides. And item by item, including the percentage of increase in cost and the cost per operation, et cetera, single payers was the cheapest one.

Mrs. ROUKEMA. Mr. Bieber, can you tell me how you want this cost allocated? How are we going to pay for it?

Mr. BIEBER. I think the President's plan provides the mechanisms for which we pay for these plans. And if we're going to talk about how we shift costs, you know, we have borne the cost, those of us who have negotiated good health care plans, have borne the cost for a long time for that roughly 40 million people out there who have no insurance.

Mrs. ROUKEMA. I was hoping that you would come forward with something more than just the President's plan because that's coming under increasing scrutiny even within his own party as to the cost savings being insupportable and the taxing mechanism lacking credibility. But we'll go on from there. Thank you.

Chairman WILLIAMS. Thank you. Mr. Martinez.

Mr. MARTINEZ. You know, I guess we have all noticed that the TV ads are now criticizing the alliances as setting up a huge bureaucracy, never mind that in the plan it allows the States to set these up and they would operate them out of the States, and I don't know how much more bureaucracy there would be than the bureaucracy that already exists the way it is now.

But regardless, there are plans in several States. In fact, there are States that we recently gave a waiver to another law to allow them to exist in Hawaii, Oregon—States that have developed their own plans already. And I guess the plan includes flexibility to allow those States to proceed with what they already have in place, which is good.

But within even a State like California, there is CALPERS. Now, Mr. McEntee, CALPERS would meet just about any criteria or standards set for alliances by the Federal Government. Now, as they understand it now, through this transition period, they would have to become a part of a greater alliance or another alliance. But actually, the Federal Government employees are in an alliance already, to the tune of 9.5 million people. And they, as I understand, as this bill would progress, would be allowed to continue that alliance.

Would you see that CALPERS ought to be—any State that has a program like CALPERS would be allowed to continue themselves as an alliance?

Mr. MCENTEE. Our position is that—and I think we differ philosophically and realistically with the administration—we believe that public sector employers in this regard should be treated exactly as private sector employers.

Now, the reason for the creation of very large health care alliances goes to, you know, the very idea of managed competition, and you have this large group of people and you'll be able to purchase this insurance at a lower cost.

But the President's program provides an opt-out for any employer with 5,000 or more people. Now, they do have to pay a penalty in terms of forming their own alliance if they have over 5,000. But we believe—and right now, under the President's plan, that

does not pertain to the public sector—we believe that that should pertain to the public sector. If there is a public sector employer with over 5,000 employees that meets the requirements, then they should be able to opt out as well.

I mean, it was very interesting—and to prove how, you know, bipartisan we are—to see Secretary of the Treasury Bentsen run over to the National Association of Manufacturers and say to them, well, maybe it's not 5,000, you know, maybe it can be 500. And then the next day, the President meets with the governors, and I don't know what the press release said, but only what I read in the paper, there seems to be some difference over this, but there was some discussion in terms of the governors, maybe there don't have to be any health care alliances at all.

We don't know what directions these negotiations will take, but I mean it's our philosophical belief that we should be treated the same as private employers.

Also important to note is the fact that the Federal employees themselves, under President Clinton's plan, will be going into the major health care alliance per State, but the postal workers will be able to continue to have their own alliance so that there is a difference even in terms of Federal workers, as you define them.

But we believe that we should have the same kind of option as a private sector employer, period.

Mr. MARTINEZ. I happen to agree with you. The problem is that we've got to make sure that the plan allows for that, because there are a lot of people who are concerned about this.

But, you know, when you talk about the Federal employees being in a major alliance and they would be allowed to go into alliances per State, I don't know that I go along with that.

The thing with the Federal employees is that you have probably the best plans that anybody can provide. There are some individual plans—in fact, CALPERS is a slightly better plan than Federal employees are offered. But with few exceptions like that, the Federal Government really has about the best plans available and actually provides all of the options that the President's plan does.

And this whole thing is administered through a very small department over at OPM in which all they do with the insurance companies is negotiate for the price of the package to make sure that that cost is contained for the Federal employees.

And I would think that if we started out to make sure that the 39 million people who are not insured—about the simplest, quickest way to get them insured is to bring them in to the Federal plan and just find a way to pay for it. Now, there have been all kinds of suggestions, such as a cigarette tax. I don't smoke, so I'm not offended by that. I don't know about beer; I would be offended by that, I do drink beer.

Mr. MCENTEE. Are they talking about taxing beer? Oh.

[Laughter.]

Mr. MARTINEZ. Well, there have been suggestions on any kind of a product that creates some kind of a health problem later on should be part of the people responsible for paying for the national health care. Now, that's a good argument, especially if you don't imbibe in any of those things, you know.

Mr. CLAY. If the gentleman will yield.

Mr. MARTINEZ. Yes, I would.

Mr. CLAY. I represent Anheuser Busch. There's no evidence that beer contributes to any health problems!

Mr. MARTINEZ. Yes, I would go along with that. In fact, one time I heard that if you drank enough beer, you wouldn't get cancer. I don't know.

Mr. MCENTEE. I think that's true.

Mr. MARTINEZ. But the point is that if we're going to talk about the easiest way to get the 39 million people insured, it's to take them into a plan that already exists and then find a way to pay for it. And most assuredly, there is going to have to be some raising of taxes to pay for it, and the Federal Government is going to have to accept the responsibility.

But I would simply ask that as we look at this plan, you see the single payer plan, which you prefer and I am absolutely one of those people that prefers the single payer plan, because for all intents and purposes, it takes the insurance company out of it. And if you look at the Federal plan, we have really a single payer plan. We contract with TransAmerica to pay everybody, and all the insurance companies file their claims, or the individuals file their claims with their insurance company, and that goes through them and it's paid out.

So I think we ought to look at some of the things that we have in place and how we expand those. And I would ask, Mr. Bieber, your comment on the idea of expanding the Federal plan to cover those 39 million.

Mr. MCENTEE. Could I make one comment, though? I think it's important to note, and we support both the principles of the Clinton plan, although we have some institutional difficulties, as well as McDermott-Wellstone, but I think it is important to note for the exponents of single payer, that in the President's plan, it allows States to set up single payer systems if they wish to do it. And we think that's a great step in the right direction.

Mr. MARTINEZ. Mr. Bieber.

Mr. BIEBER. Well, Congressman, my answer to you would be this. Obviously, we know that there are going to be negotiations on this plan as it goes through the process. I am concerned, as I laid out in my opening remarks, there are some basic things that have to be there if we're going to support the final draft.

I'm open to listening and to looking at these plans. I do have concern, when we talk about all the opt-outs and the opt-ins, that we don't get into a situation of, regardless of how we set up this plan, if you've got an alliance out there and you allow everybody to opt out with all of their high-cost people, you're going to set up an impossible situation. My druthers would be no opt-outs, no opt-outs.

Chairman WILLIAMS. The gentleman's time has expired. Mr. Fawell.

Mr. FAWELL. Thank you, Mr. Chairman. I would like to just center in regard to the so-called early retirees' treatment here. I think I am—let me make this example. If I am, let us say, Jay Rockefeller, and I take early retirement, and I'm between the ages of 55 and 65, government pays 80 percent of the cost of my policy. Am I incorrect there?

Ms. BORZI. There is a salary.

Mr. FAWELL. There is a salary. All right, what is that, if I may ask? I'm now propounding a question to other than the witness.

Ms. BORZI. It applies only to early retirees with an adjusted gross income of less than $90,000.

Mr. FAWELL. To $115,000.

Ms. BORZI. [continuing] of $115,000. So it isn't Senator Rockefeller, someone less well off.

Mr. MCENTEE. Pick another senator.

Chairman WILLIAMS. It's going to be hard to find a senator. Maybe you ought to go to House members.

[Laughter.]

Mr. FAWELL. All right, so I don't know how—this is partially based on my ignorance of the specifics, I gather, but I don't know how one then determines if one is no longer full-time employed and between the ages of 55 and 65, one falls into this category of being an early retiree.

In fact, it would appear to be—it isn't necessary that he be a retiree, it just is the fact that he's between the ages of 55 and 65, is laid off or whatever, and apparently does not have income of more than $90,000, or whatever it may be. I'm not sure at that point, not being full-time, not drawing a pay check, how they determine the $90,000 of income. I suppose it's dividends, I don't know.

But my first point is, I gather we're talking about people who are not employed full-time, which means that they're not working more than 30 hours, I guess, per week, under the definitions of what is full-time.

So it is a bit more than just early retirees we're talking about here, I gather. But if we're talking about the Lee Iacoccas who are terribly, terribly wealthy——

Mr. BIEBER. He doesn't need it.

Mr. FAWELL. He doesn't need it and he doesn't get it, and I think that's a plus. But on the other hand, if I am John Smith and I am age 51 and laid off, I get no aid either. That is correct, I assume.

So my point is, what we're doing here is picking out—we often do this in Congress; we misname everything or we give it the name that will sell best, but we're talking about more than early retirees. That's one point I gather is correct here. We're talking about a special group of people who happen to fall between certain age categories.

But on the other hand, there are a lot of other people, the guy at 50 who is laid off, who otherwise would qualify, but he's not old enough. But he's old enough to have trouble, let's say, as a member of the middle class to be able to make ends meet. But he doesn't get the 80 percent subsidy.

Mr. BIEBER. Well, sure, he would. Under the President's plan, if he's laid off, he has no coverage——

Mr. FAWELL. Well, I assume he's got income, though. And let's say he takes a lower paying job. But he does not, I assume, unless he falls under the poverty classification, whereby the government would then commence to pay a portion, that he doesn't fit within this definition.

Mr. BIEBER. The President's plan, unless I've missed something, and I don't think I have, is a health security plan. Those people

that you describe that are laid off, et cetera, are going to be covered under that plan.

Mr. FAWELL. Let me put it this way. Just the fellow who is middle class, he's got a job or he took a step down when he was laid off, very young—any number of other classifications would probably have some reasonable argument that they should gain this subsidy also. We give it only to a certain class.

And my question really is, aren't there are other groups of people who also would have as much of an argument for a subsidy having to pay their 20 percent and also would have a right to have this type of a classification apply to them?

Mr. BIEBER. But, sir, the retiree is going to have to pay the 20 percent, too. The person who you are describing would be covered—if you have the employer mandate, which certainly has to be there, he's going to be covered by that 80 percent as well. The early retiree you're talking about doesn't get a free handout. He's going to get the same coverage.

Mr. FAWELL. I see. So if he is employed, he gets the 80 percent coverage.

Mr. BIEBER. Sure.

Mr. FAWELL. The person who is in the 55-to-65 category, will he be entitled to the 20 percent coverage also if there is an obligation from the employer to give him 100 percent payment, for instance? Will he pick up the 20 percent, then, too?

Mr. BIEBER. Well, under the plan as it's now provided, if this were a member of my union, where you had an ongoing company, you would be allowed—if you could do it, you would be allowed to sit down and negotiate with the employer to pick up the 20 percent. But if that isn't the case, then the retiree has to pay the 20 percent.

Mr. FAWELL. So if the employer, though, let us say, has obligated himself or herself to pay 100 percent of the health care costs, he would be relieved of 80 percent, but would still have to pay the 20 percent?

Mr. BIEBER. Under the example you just gave, if an employer was committed to pay the 100 percent and the program went in, his cost now would be 20 percent.

Mr. FAWELL. So that particular person without a job, not necessarily being an early retiree, would have 100 percent coverage.

Well, my only point is that that is obviously a very favorable thing for the employee. On the other hand, all the people within the regional alliance and/or the taxpayers are going to have to figure out how to pay for that.

But I would think that others, who are unemployed, but not within that category, could make a pretty forceful argument that they would like to have that same kind of treatment.

Mr. BIEBER. That's what we're talking about—they both would get the treatment of 80 percent. It is the same kind of treatment.

Mr. FAWELL. Well, if you're unemployed and if you're age 51, the government is not picking up 80 percent, are they?

Mr. BIEBER. But the unemployed who have no insurance, unless I've missed something, and I don't think I have, would be covered under the President's program. They would be covered, period.

Mr. MCENTEE. Yes. Somebody unemployed or on strike or whatever would be covered by the President's package.

Chairman WILLIAMS. The gentleman's time is expired.

Mr. FAWELL. Well, if I may say, I think there is no subsidy there for him, but maybe I'm mistaken.

Chairman WILLIAMS. Chairman Clay.

Mr. CLAY. Thank you, Mr. Chairman. This is to Mr. McEntee. My office is getting some letters, not too many, from people that we have identified themselves with the National Association of Manufacturers and the Business Roundtable, that are in support of the Cooper bill. Will you express your opinion on that bill?

Mr. MCENTEE. Yes. We're opposed to the Cooper bill for any number of reasons. First of all, it doesn't meet the requirement for universal coverage for all Americans in terms of some of the types of payment for the Cooper bill. And this is one of the real problems, we think, with the Cooper-Breaux bill, if you will. They talk about taking away the present existence of a tax deductibility for the idea of giving health care benefits to their workers.

If that were to happen, we think our people would suffer as well as the business community suffer as well. They also talk about a tax in the public sector that would be an excise tax to pay for the Cooper-Breaux bill. That would end up being an excise tax on the value of the benefits.

They say all these kinds of things, and then when you ask them, well, what is the benefit package, they refer you to page 92, or whatever it is—it's not as long as the President's bill—to page 92, and they say they're going to set up a commission that will then set up the benefit package.

We think the Cooper bill does not meet the basic principles in terms of universal coverage. We have no idea what kind of benefit package it is talking about. And we think this—I mean, in all fairness, and someone had remarked earlier about the President's proposed legislation coming under scrutiny—we think one of the real problems thus far developing in the country and most certainly in the press is that it's only the President's bill that has come under scrutiny.

I think if people really look at the Cooper-Breaux bill, I mean in terms of the type of taxes and where those taxes are going, it's really a tax increase on the middle class, as far as we're concerned, the Cooper-Breaux bill, and without even telling the American people what kind of package of benefits they're going to get for it. And it is not national health care reform because it doesn't provide universal coverage.

And we would just wish, we would just hope that everybody would put Cooper-Breaux and Chafee and Michel under the same kind of microscope that they put the President's plan.

Mr. CLAY. Thank you. Mr. Sweeney, speaking of universal coverage, what would happen if the President's plan for 80 percent contribution by the employer were eliminated from the bill? Do you think we could accomplish universal coverage?

Mr. SWEENEY. If the 80 percent was eliminated? No. In all of this, I mean, earlier we heard a lot of discussion about early retirees. There is a lot of misinformation and a lot of misunderstanding. The basic, bottom line of all of this is that, in terms of the focus

on labor-management, health care has been a crisis for the past several years in every collective bargaining situation—early retirees, young retirees, old retirees, old workers, every kind of worker that you could imagine, every person in this country.

And if we are going to have meaningful health care reform, we have to have universal coverage, and that either has to be a single payer kind of approach or a mandated employer coverage.

Mr. CLAY. Are there any other advantages of the employer mandate over the individual mandate?

Mr. SWEENEY. The individual mandate is nothing but a voluntary program, and a voluntary program will never work. As every American is entitled—there is a basic right to health care, every employer should have to provide that health care coverage, and it is only fair that everybody pays their fair share.

Right now, good employers with decent health coverage are subsidizing their competition who are not providing any health coverage.

Mr. CLAY. Thank you, Mr. Chairman.

Chairman WILLIAMS. Thank you. Mr. McKeon.

Mr. MCKEON. Thank you, Mr. Chairman. You all mentioned, I believe, that the increased costs, the way the costs are being driven up, is one of the major problems, one of the major reasons why we need health care reform. And I think everybody agrees to that. It's what is causing those increases and how you would address that. It's a very complicated issue.

A doctor in my district was telling me a story, just one story of a renal dialysis. Ten years ago, a doctor was being paid $500 to perform renal dialysis, and it was costing the government under Medicare about $500 million a year. Now, 10 years later, the doctor is still receiving $500 for performing the renal dialysis, but the cost to the government is now $6 billion a year because of the increased—you know, the aging of our population and the increased use of the medical practice.

Now, how would you see the President's plan addressing this? How is that going to reduce those costs?

Mr. SWEENEY. Well, if we start with the basic assumption that you can't have health care reform unless you have a meaningful cost containment program—whatever plan the Congress comes up with, it has got to have effective cost controls in order to have true health care reform, whether it's the cost of health to the employer or it's the cost of health to the individual or it's the cost of health to the Nation.

We think that the President's proposal is a very effective proposal in terms of controlling costs, and if there is some disagreement with some pieces of that, then we have to find substitute, but we have to have cost control in order to have effective health reform.

Mr. MCKEON. Let me just also—in that particular example there, and maybe you could address this in the follow-up, how would you further control that? In other words, if the doctor was receiving a payment 10 years ago, we know that with inflation, his costs have gone up, his rent, his employees, and he's still receiving the same payment, what further cost controls do you place?

Mr. McENTEE. Well, I think the President is talking about global budgeting, he's talking about the health care alliances, where consumers would come together to negotiate costs. I haven't met many poor doctors in my life. I think what we're looking at is some medical costs.

We have situations, for example, I know in the State of Pennsylvania, personally, where you can go in for open heart surgery in one section of the State, a particular doctor, and it may cost you $10,000; you go into another part of the State of Pennsylvania, same procedure, same everything else, and it might cost you $25,000.

I mean, it's all over the place. And it's not only the cost in terms of the medical profession that have had no controls at all, it's also the pharmaceutical industry, the money that's made in the pharmaceutical industry, with no kind of control, no kind of accountability. It's the money made in the insurance industry, with no control and no kind of accountability. And that's why they have so many commercials on television, because they would be satisfied with the status quo.

Mr. McKEON. You know, I don't hear that either of those are answers to my particular example, unless you're saying, because we don't have poor doctors—do you want to cut the $500, then, to $250 to perform the renal dialysis? Or do we want to cut the number of people that we let have the renal dialysis? What other way do you cut the cost on that particular example?

Mr. BIEBER. Well, one way you cut the cost, first of all, is to see to it that everyone in the country is part of the program. You know, I'm not going to argue about the $500. There are a lot of doctors in this country who have conscience, et cetera. But I also must say to you, sir, that the examples of a doctor who is still charging the same for a benefit today as he was 10 years ago——

Mr. McKEON. Well, the doctor doesn't charge that. That's decided by the DRGs and——

Mr. BIEBER. But that is not the across-the-board situation. I'm not here to argue what doctors are paid, but if we want to——

Mr. McKEON. I'm not trying to argue. I would just like to know how you would solve that problem.

Mr. BIEBER. Well, there are a number of ways you do it. First of all, in the President's plan, there is strong cost containment. You're not going to beat this battle unless you put that in there. You can take out a lot of unnecessary cost, paper shuffling, paper handling, through the President's program. So there are a lot of savings that are in there.

I don't know if what is on paper right now is going to take care of every single situation. But, sir, I do know one thing, that the health care delivery system that we have in this country now is not working. It is not working. And I doubt that you will find many people who will tell you that it is.

And we can look at some more band-aiding. That's what we have been doing for years now. That isn't going to take care of it either. But we need to look at how this all reflects upon our competitiveness as a country. These things put us at a terrible disadvantage, and the President is now trying to take care of those problems.

When you get all done here on the Hill, the bill you enact may not be the perfect bill, and you may have to go back and change some of that. But I think what we have to accept is the fact that the system that we have is not working, and we've got to look to find a better way.

Mr. MCKEON. I think when we say it's not working, maybe you can find instances and you compare them, certain instances, but I think when we talk about our competitiveness worldwide, I have been to other countries, and I know that people in other countries that can afford medical care, if they get sick, they come here.

And I think that we maybe have criticized our medical care more than need be. I think our doctors, our hospitals, yes, we do have definite problems, but I think that we do provide the best medical care in the world. And I think that rather than throw it all out and start over, what I would like to see us do—you might call it a band-aid approach, but I think there are things that we need to fix.

We need to fix portability, we need to fix preexisting conditions, but to totally throw out what we have and start over, I think we'll end up taking our medical care downhill and then we will be like the rest of the world in the kind of care we provide.

Mr. MCENTEE. If I could just make a comment, I'm not sure that President Clinton's plan, proposed plan, would throw literally everything out and we would have to start over. I would agree with you, and firmly believe this, that in terms of quality of health care, our country is second to none. The only problem is, you have to have money to pay for that. And we still have 38 million people without any at all, any type of health care, 75 million with inadequate health care.

In terms of the quality, I think we do have the best quality, but you have to have that kind of money to afford that kind of quality. That's what has to be changed.

Chairman WILLIAMS. The gentleman's time has expired.

Mr. MCKEON. Thank you very much.

Chairman WILLIAMS. You're welcome. Mrs. Unsoeld.

Mrs. UNSOELD. Thank you, Mr. Chairman. The President has said, Mrs. Clinton has said, and others have said, Mr. McKeon, that the President's plan will retain what is best about American health care and fix what isn't. And nobody is suggesting we throw it all out except those who oppose doing anything about health care.

Mr. Williams, would you like me to yield to you so you can straighten out any of the discussion on retirees and laid off and so forth?

Chairman WILLIAMS. Well, it is a complex matter. We have had several briefings from the administration on it. I guess basically what folks need to understand is that any retiree, including retirees from local and State government, who are between the ages of 55 and 64 years old, will be eligible for coverage and receive a subsidy, a subsidy equivalent to what the employer would pay, which is 80 percent.

Coverage, by the way, is not only for the early retiree, but is for their dependents and their spouse as well, so it's family coverage. The requirements are that the early retiree is not employed full-time, which means 30 hours. The second requirement is that that

person will be eligible for Medicare Part A, and the third piece of criteria is the $90,000 to $115,000, at which the subsidy—between $90,000 and $115,000, there is phase-out.

With regard to Mr. Fawell's question, which went to the unemployed person who is age 51, that person would be covered and also, like all the unemployed, would receive help in paying those premiums.

I thank the gentlelady for yielding and return her time.

Mrs. UNSOELD. Those lights flash fairly rapidly, and some of you were poised to speak when they went red. If any of you would like to add anything on my time to what has been said or that you were about to say when you got cut off, I yield to you.

Mr. MCENTEE. If I could just make one comment in terms of the early retirement. As we have watched both in the private sector and the public sector, we see more and more and more of this by virtue of the restructuring in so many industries in the private sector, where people just get out. I can't necessarily say that they're forced out, but you know, there are obviously either layoffs or, you know, if we're not going to have layoffs, maybe these people can take early retirement. We have seen more and more situations where there is a buyout for early retirement, where there may be a severance for early retirement.

Right now—I had mentioned the city of New York—they're talking about laying off 11,000 to 15,000 people, but they're talking about giving them a severance. And they'll give them severance pay if they'll take early retirement and go.

And you see many of these kinds of situations developing as our economy becomes restructured, not only in the private sector, but the public sector as well. And if it's not taken care of, you're just going to have hundreds of thousands of people out there without coverage. We think it's really very, very necessary.

And it helps considerably with the restructuring that may be necessary in certain industries and in cities and States.

Chairman WILLIAMS. If I might use the gentlelady's time to ask Mr. Sweeney this. The recommendation is that public employers be able to establish their own alliances, just like the large corporations can under the President's plan. The question for the White House and for us here on the Hill is whether or not doing that would create a political uproar.

So I guess my question requires you to use the judgment of your political senses in this. Would it create a political uproar if all private employers had to cover their employees under a regional alliance, but State and local employees would be exempt? I know what Mr. McEntee thinks about this, but I wanted to have further benefit of your thoughts on it.

Mr. SWEENEY. Are you insinuating that there is no unity at this table, Mr. Chairman? I just want to say that Gerry McEntee has very articulately expressed our concern in terms of public sector workers want to be treated the same as private sector workers in national health care reform, and I do not think that it is as sensitive a political question as you might think.

I think that we have an obligation to provide the same kind of structure and the same kind of benefit package and the same kind

of opt-out provisions for the public sector as we will hopefully provide for the private sector.

Mr. BIEBER. If I might, Mr. Chairman, to underscore the unanimity here, I know that when I appear here as president of the United Auto Workers, that some people may assume that's all I represent. For the record, the largest single local union in the UAW today happens to be the Michigan State workers.

Mr. MCENTEE. What?

Mr. BIEBER. A unit of 25,000. So I want everybody to understand that the UAW agrees, and I agree with my two colleagues here on that issue as well.

Chairman WILLIAMS. Well, it's always fun to poke a little bit at the leaders of organized labor to see if solidarity is still alive and well, and I see it is, with the exception of the—with the single exception of Gerry's members being in your union.

Mr. MCENTEE. Hey.

[Laughter.]

Chairman WILLIAMS. Oh, God, let's start a fight. Mr. Klink, I think you had come early and left, and Mr. Green, I'm sorry, I see you're back. Do you want to yield to Mr. Reed or to Mr. Hoekstra or to Mr. Ballenger or to Mr. Gunderson?

Mr. KLINK. I have questions.

Mr. BALLENGER. As a Republican, next in line, could I ask?

Chairman WILLIAMS. You certainly may.

Mr. BALLENGER. As a businessman who has been worried about the same problems that you all have been worried about for years—I think we started our health insurance plan in my company 35 years ago, and every 5 or 10 years, you've got to change it because we started off with a list of surgical things that were performed and the regular package that would cover it, and that went by the boards. And then we went to major medical and covered it with catastrophic, and then that went by the board. And then we went to self-insured with managed competition and PPOs, trying to do the same thing you all have been trying to do, and over and over again, it just keeps somehow shifting away from us.

Now, there are a couple of things that I would like to bring up that I think have been ignored, to a very large extent, in the President's package, and I would love your opinion of it, and that's the fact that defensive medicine is so damned expensive today. You know as well as I do, if you go out and have an automobile accident and they take you to the doctor's office and they give you a blood test and a urinalysis and X-ray and all the necessary things, and then the doctor says, "You're not in very good shape, we had better send you to the hospital."

So they take you to the hospital and they give you a blood test and a urinalysis, the same thing all over again, and everybody just covering their you-know-what, and this is all because of, in my considered opinion, a need for some sort of tort reform.

I know it's not the cost of the malpractice insurance itself. It's just the threat that the doctor and the hospital may get sued, so they do all this additional stuff, and in the bill itself, it seems to say, "Oh, we're taking care of that, we're only going to have the lawyers get 30 percent of the settlement," or whatever it may be,

which is exactly the same without the bill. That's what everybody is getting right now.

I was just wondering if there is some opinion on your part that—I have heard numbers mentioned anywhere from $7 billion to $28 billion as the cost, because of defensive medicine, of the cost of health care. And I just wondered if you all don't see some weakness as far as the President's plan in not attacking that particular problem. And I don't want you to get all the lawyers mad at you, but I'm just curious.

Mr. SWEENEY. I'm not sure that we would look at it as weaknesses in the President's plan. We would certainly, I think, agree with you that the whole tort reform and malpractice issues have to be addressed at some point in this process, and the effect that it has on health care costs has to be addressed in terms of cost containment, and so on.

The whole area of defensive medicine has to be focused on in terms of providing quality care, but eliminating waste and eliminating duplication of services and all that kind of concern that we have as well as—we share your concerns, and we hope that the Congress will address it.

Mr. BALLENGER. Well, let me ask Mr. Bieber one question. We've got a General Electric plant in my home town, and they called me out there, oh, a month and a half ago or something. And so we just sat down and discussed—I had gone over—you know, the bill itself has a 7.9 percent cap on percentage of cost of payroll that it's not going to go over supposedly.

So I checked my own payroll out, and realizing that the union had got much better negotiations—you all have done a good job of getting better health benefits for your employees, and you don't represent GE, but somebody does.

Mr. BIEBER. Oh, I have some of the GE——

Mr. BALLENGER. Okay.

Mr. MCENTEE. We don't have any.

[Laughter.]

Mr. BALLENGER. The problem, though, when I sat down to discuss with them, I checked my own and I agree that we don't have the Cadillac plan, but I think we've got as good a plan as the President's got. And as a percentage of payroll, it's only 6 percent of my company. But at the GE plant, it was over 11 percent, and when you come down to the 7.9 percent cap, it seems to me that we're doing a favor—I don't know what it is at General Motors or Ford or any of those, but I'll bet you two bits it's more than 7.9 percent.

They're getting—it appears to me they're getting a windfall, and all us little guys that maybe negotiated tougher, or didn't have the money to spend the way the automobile and the big companies did, are going to have to jump ours from 6 percent, in my case, to 7.9 percent, and they're going to drop theirs from 11 percent down to 7.9 percent. What do you think of that argument?

Mr. BIEBER. I understand what you're saying, but I think you have to also take into consideration that one of the reasons that—if you look at General Motors and Ford and probably GE—I haven't look at that particularly; I don't have the major portion of GE—you're going to find that a good piece of why that cost is up there

is because we are frankly picking up the insurance costs of other employers.

Mr. BALLENGER. Oh, yes. Well, the same thing with me, though.

Mr. BIEBER. Well, but my point is, we have many, many employers who don't provide any coverage.

Mr. BALLENGER. I agree.

Mr. BIEBER. So that when I negotiate for coverage at General Motors for a Mr. Sweeney, whose wife works somewhere else, they don't provide anything, we're picking up all of that. And so that's what runs that price up there considerably. So it's not a windfall for those people.

Mr. BALLENGER. But, see, I give my employees everything, the same thing that you do—probably my plan is not as good as yours, but I am paying the same penalty that you are. I agree with you. We're paying everybody that's not insured's cost.

Mr. MCENTEE. Could I make one point?

Mr. BALLENGER. Sure.

Mr. MCENTEE. As you said, you think—and good for you—that your plan, you believe, is not necessarily a Cadillac plan, but it meets, you know, the President's plan in terms of what he has. You don't have to increase your cost. The 7.9 percent is a cap. You can stay just where you are.

Mr. BALLENGER. Well, I agree with you there, but I have absolutely no confidence in the Federal Government's ability to pick out a percentage that's going to be—except I know to start with that the big boys who are paying more than that are going to jump on board the 7.9 percent just like that.

Mr. MCENTEE. First of all, I understand that's structured in over a period of time. That's structured in over a period of time.

Another economic consideration is, and you've heard this figure so often in the past, Iacocca using it so much, that the cost in terms of a Chrysler as compared to imports was $700, $800 a car, something like that. So when you're talking about a global economy and you're talking about economic incentives, that can be one of the best economic incentives that we have ever made.

Mr. BALLENGER. I agree, and I compete with the people in Hong Kong and Taiwan and accept that as a fact. I was just trying to bring up a small businessman's viewpoint. In fact, somewhere along the line, I have no great—I mean, the guesstimate that they said the cost of Medicaid was going to be, which was a million miles away; the guess on Medicare was a million miles away.

And when you take the service that they provide to Medicare and Medicaid patients and Veterans Administration, all of these medical plans that have been run by our Federal Government deliver a lousy product, and all of a sudden—in fact, we asked Mrs. Clinton about this, and she said, yeah, but we're going to do it better.

I've got a bridge I would like to sell somebody if they really believe that statement. I just can't see the Federal Government running anything worth a damn.

[Laughter.]

Mr. BALLENGER. Completely unbiased statement.

Mr. MCENTEE. I thought we had a pretty good Army and Navy and, you know——

Mr. BALLENGER. Well, I'll agree with that.

Mr. McENTEE. But I would applaud you as a small businessman, I mean in terms of providing that kind of health care benefit to your people. And if small businessmen all across the United States had done that, we might not have the crisis we have today.

Chairman WILLIAMS. The gentleman's time has expired. The gentleman from Nebraska I think is expressing—although I'm not entirely in concert with his——

Mr. GREEN. North Carolina.

Chairman WILLIAMS. I'm sorry, North Carolina, I'm sorry.

Mr. GREEN. That's all right.

Chairman WILLIAMS. I was just in Nebraska. Yes, that's not a Nebraska accent. I'm still back in Nebraska. I'm sorry.

The gentleman from North Carolina is expressing a concern that I—although I don't fully support it, I do recognize that a significant majority of people in the United States do.

I saw an interesting thing the other day, that when Jack Kennedy was President, almost 80 percent of the American people had trust in the Federal Government and, in fact, believed the Federal Government could do great things. Today that's 18 percent.

And so the difficulty is that the Congress of the United States and the President of the United States are being asked by the American people to reform the way campaigns are run, reform welfare, and reform health care at the same time that the people demanding we do it do not believe we can do it correctly. It's a dilemma, and we're all in it.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. I just have one question. I wish I had more UAW employees in my district because of the health thing, but I know I have SEIU and also AFSCME. And the concern is that some of the lower paid government employees, with the health care plans that we have, both the city of Houston and Houston School District, that SEIU have, and the lack of a plan in some cases for people who are just barely above minimum wage, and how would this, the President's plan respond both to government employees, but also to small business?

And let me give you an example. The cap for small business is 3.9 percent. What I've been told, though, is that to do that on small businesses, you have to show a corporate profit, and it's reimbursed; it's not a real cap. And if you could address that, but also see how this would affect some of your lower paid members of both the unions.

Mr. McENTEE. Ours is a mixture. We have some very large locals and councils in our union that, just as the gentleman said from North Carolina, the packages that the union has been able to negotiate are actually better than the package that the President is bringing forth.

But naturally, the concern has been, and I think Owen addressed it earlier, or John Sweeney, over the past decade, every time we have gone to the collective bargaining table because of the escalation of health care cost, the refrain that we have heard is that, you know, either, "We have to reduce your health care plan," or, "You don't get any wage increase," or maybe, "You get 1 percent."

And our people, through that decade from, I guess, you know, the mid–1980s on have been taking zero wage increases or one or two

just to keep their health care plan, and then for a large part that's been reduced as well.

And then we have another group of workers from some communities where their health care plan is totally and absolutely inadequate in terms—I mean, we have them—you know, it only covers the worker, it doesn't cover the spouse, it doesn't cover the dependents, there are all kinds of deductibles. I mean just, you know, it's a very, very minimum kind of plan and a tremendous out-of-pocket cost for those people.

And yet it's that whole conglomerate of workers that's paying for people that are uncovered. And it does kind of hitch itself on. It's that whole conglomerate of workers that now pays for small business that does not provide the care to their people, because their workers will get care. They'll get it through the emergency process or some other process; they'll get the care.

And our people, where we have negotiated good contracts and some not so good, are paying that, by virtue of cost shifting, with their premiums. So in some places, this would be a very, very big help in terms of inadequate health care that we have, and it would also be a tremendous help in terms of taking the cost and spreading it all across our society.

Chairman WILLIAMS. Mr. Green, let me just ask you to yield to me for 30 seconds. Mr. Sweeney has to leave. We've gone a bit over, and I know, John, that you're being pressed here on time and we want to excuse you. But thank you very much for taking this morning to be with us, and we look for your and your union's members' continued counsel and help as we try to move this through.

Mr. SWEENEY. Thank you very much, Mr. Chairman, and I am delighted to have this opportunity to be on this panel and am really impressed with the number of members of the subcommittee who have participated in this hearing this morning. It just shows how serious the Congress is taking the issue. It's an issue that we certainly in the labor movement have been championing for many, many years, and it has a very, very serious effect on every single American.

I would just hope that in our continuing discussions that some of the issues that have been raised in questions today, that we could have more opportunity for discussing these areas because they're very important. I mean, whether it's the early retiree issue or it's Congressman McKeon's addressing individual nightmare stories, we have to find the solutions and we have to find the answers. And I don't think we can do it on the specific examples that we're seeing, we have to do it on the broad set of principles in terms of achieving national health care reform.

So thank you very much, Mr. Chairman and all the members of the committee.

Chairman WILLIAMS. Thank you. I know, Mr. Sweeney, as we all do, that labor has been long supportive of this. Many Americans I think have not yet discovered that the first President to ask for national health care was Roosevelt—Teddy. So I don't know if that predates labor support for this or not, but we know that you have a long history of support.

I also want to continue to use the gentleman's time to say that Mr. Bieber has a 12:40 flight. And so perhaps if we could ask the

remaining members—and Mr. Sweeney, I believe you have to leave right now, but if the remaining members could just take maybe a minute each.

Mr. GREEN. Mr. Chairman, I'll yield back my time to the members who haven't had the opportunity to ask questions.

Chairman WILLIAMS. Mr. Reed or Mr. Hoekstra, either. Mr. Hoekstra.

Mr. HOEKSTRA. Mr. Bieber, welcome. Good to have you here. Do you have an example of a union contract, a relationship with a corporation that you feel maybe models or has really aggressively gone out after the health care cost for their business and perhaps has used it as a competitive tool successfully?

Mr. BIEBER. Well, yes. I would point to the Big Three auto producers. In Chrysler we started out there to jointly work on insurance programs to reduce the cost back in 1979, 1980, when they were having their major problem, their brush with bankruptcy. We have worked very closely with the insurance carriers, with the companies, to reduce the cost. We have worked closely to work out unnecessary admittances, duplication.

I go back far enough to remember when every person who was going into the hospital for surgery on Monday got admitted on Friday night. And we have worked all of those things, and we have saved a great deal of money.

But we can't handle the problem where you have all these uninsured people and other companies who don't pick up their weight in the boat, so to speak.

Mr. HOEKSTRA. Go to Mr. Gunderson. He has been waiting and I rudely avoided that because I had thought that he had asked questions earlier. I apologize, Steve.

Mr. GUNDERSON. No problem. I want to ask you very quickly some things that may or may not be deal breakers. Let's assume we have universal coverage through an individual mandate. Would that cause you to lose support—take away your support for the bill?

Mr. BIEBER. Sure.

Mr. MCENTEE. Yes.

Mr. GUNDERSON. Even though it's universal coverage?

Mr. MCENTEE. Yes.

Mr. BIEBER. You got to pay for it somehow.

Mr. MCENTEE. Yes. Who is going to pay for it?

Mr. GUNDERSON. Well, if it's all going to be on budget, it doesn't matter. I mean, sure, if you have universal coverage, the government is going to pay for it. I would think you would be delighted with that.

What happens if we drop global budgets? Is that a deal breaker for you?

Mr. BIEBER. If we did what?

Mr. GUNDERSON. Dropped global budgets.

Mr. BIEBER. Yes.

Mr. GUNDERSON. If we drop price controls, is that a deal breaker? You would no longer support the package?

Mr. BIEBER. Well, I don't know what you—your term of "price controls" is probably different than what I am assuming.

Mr. GUNDERSON. I'm just assuming the Clinton package. I'm just trying to take these things because, I mean, you all well know, there are not the votes there today to pass any plan. Either we're going to find a way to merge some plans or we're not going to do health care. And if you people believe what you said about the need for health care reform, and I think you do, then we all got on all sides to set some of this rhetoric on the shelf now—we've done it for a year, and figure out how we get together to pass health care reform in 1994.

So I'm trying to literally figure out—the President said, "Universal coverage, that's my one deal breaker. If that's not in the bill, I won't support it." Well, we can get universal coverage; there are a lot of options on how to get that. What I'm trying to figure out is, what else are deal breakers? Is the early retirement thing a deal breaker? If that's taken out, is your support gone?

Mr. MCENTEE. If I could answer that?

Mr. GUNDERSON. Sure.

Mr. MCENTEE. We think that—and we agree with you that obviously the President's plan as written, or Wellstone or Chafee, is not going to go through as they have been proposed. I think it's difficult, you know, to be in a position here to say—or to ask the two of us—difficult for us to answer, really, what is or is not a deal breaker.

I mean, the President has talked about, I mean, four or five different principles in terms of quality and coverage and things like that. They're all tremendously important.

I don't think we can call, as you ask us, on a single, particular item whether that's a deal breaker or not. Things are going to change, things are going to be negotiated. We seldom approach a negotiating process very early in the game and say to the employer, if we don't get this, you know, this is a deal breaker.

What we want to do with the Congress of the United States is bring forth some of the things we're in favor of, some of the things that we would like to discuss, and then somewhere down the line, make it absolutely clear if there is some legislation that really starts to formulate the kind of thing we can support and the kind of thing that we can't support.

Something may be a deal breaker for the auto workers that maybe isn't for us, and vice versa.

Mr. GUNDERSON. I appreciate that, because if employer mandates is a deal breaker, I don't think we pass health care.

Mr. BIEBER. Well, we may not, but I was speaking for myself and the members that I represent. We are working very hard for the Clinton plan. It isn't everything we want. But I would have to say to you that we would not be in support of a plan that's going to be a hoax, an empty box, And if you don't look at universal coverage, if you don't——

Mr. GUNDERSON. Owen, Owen, listen to me. I said, assuming we guarantee universal coverage, are you flexible on how we achieve it?

Mr. BIEBER. Well, that's a pretty broad question. If you want to change four words in 20 paragraphs or one word in 100, that makes a difference.

Mr. GUNDERSON. Owen, an empty box is an employer mandate phased in over 15 years that exempts every business under 50. That's an empty box.

Mr. BIEBER. That's one part of an empty box.

Mr. GUNDERSON. But if you want to play a semantic debate, you can say, well, we had universal coverage and we had an employer mandate. Yes, you did, not in your lifetime and mine, probably, but we had it. I mean, see, that's what I'm trying to get at—what are the parameters under which we can try to bring this committee and the Congress together?

Mr. BIEBER. Let me—not to be argumentative, but to point out something else. Another 17 months I'm retiring. I've been at collective bargaining tables since I was 19 years old. I just celebrated my 64th birthday. I never learned to go to a bargaining table and suggest to the people who are going to be bargaining a package with all of us that, here's what I'm talking about, but really my bottom line is only two items out of 100.

And it would be pretty foolish for me or for you, vice versa, to take that position this morning. I think if you will carefully look at the long version of my testimony——

Mr. GUNDERSON. Which I did read.

Mr. BIEBER. [continuing] you will see, there are basic things in there I don't believe can be moved and that we would not support. Now, I'm not sitting here this morning and saying it has to be every word from word one to one million and one that's in the package.

But in all due respect to you, and I would respect you saying the same thing to me, I'm not about to sit here this morning and start running down the list and say, well, you can move this off and this off and this off, because it's not quite that easy.

Mr. GUNDERSON. Okay, so then you are saying there are no deal breakers?

Mr. BIEBER. Pardon?

Mr. GUNDERSON. Then there are no deal breakers as of February 2?

Mr. BIEBER. Oh, yes, there are some deal breakers.

Mr. MCENTEE. We want to look at the package.

Mr. BIEBER. Universal coverage is a deal breaker. If it's not there, it's a deal breaker.

Mr. MCENTEE. We want to look at the package.

Mr. GUNDERSON. Okay, if universal coverage is a deal breaker and that's it, that's helpful.

Mr. BIEBER. No, that's not it and you understand——

Chairman WILLIAMS. We are obviously not going to get Mr. Bieber to his plane if we use this as a collective bargaining——

[Laughter.]

Mr. MCENTEE. Mr. Chairman, we even disagree with the President with his deal breakers and negotiating—you know, he seems to be negotiating with the governors and he's negotiating with somebody else. We're still having these hearings, you're still having these hearings. We would have thought that he would have waited a while, but, you know, maybe he never negotiated a contract.

Chairman WILLIAMS. I do want to say, I understand what Mr. Bieber's response to Mr. Gunderson is, which is, it's too early or

may not be the right place to begin to try to say what's on or off and what's a deal breaker and what isn't. But Steve is one of the best representatives on his side, along of course with the ranking member, Mrs. Roukema, in trying to find a reasonable ground for compromise.

And the committee is going to be working, both Republicans and Democrats, to attempt to find that, and I think Steve started that process here with you today.

Mr. BIEBER. Well, and I understand that and if the congressman and I could go out here and find a room and we could sit down and negotiate this eyeball to eyeball, I would love to do that. And if we get to that point, I'll be happy to come back.

Mr. MCENTEE. We would like to have a seat at the table when you really talk about deal breakers. We would like that.

Chairman WILLIAMS. It's obviously easier to get a seat at the table with the White House than it is with the House of Representatives.

Now, Mr. Bieber, if you would be patient for just one more minute, Mr. Reed has been the most patient guy, and he hasn't had an opportunity yet.

Mr. REED. I have a short question, characteristically. You talked about the lack of parity between public and private plans. You indicated that one element was the lack of an ability to have a corporate alliance as private industry could. Are there other elements lacking in parity that you could outline so we could consider them as we go forward?

Mr. MCENTEE. Yes. Another major one is—and I guess the major one—is the fact that we have been having discussions all morning about the cap, the 7.9 percent cap. In the President's plan, the 7.9 percent cap does not apply to the public sector, and once again, we believe in parity and equal treatment. And if that's what is going to happen in terms of the private sector, that's the cap, then the same kind of cap ought to apply to the public sector as well.

Mr. REED. Can I follow that up?

Chairman WILLIAMS. Sure.

Mr. REED. I think the presumption of the President's cap is that the legal requirement for an employer would be just to pay 80 percent of the basic plan.

Would you also see that as something in terms of the cap so that the city or the State would pay 80 percent of the average cost of the plan and the employee would pay 20 percent?

Mr. MCENTEE. The employee pay 20 percent? Well, we believe that's a negotiable item, even under the President's plan, in terms of contracts being preserved in that manner for the first 10 years of the plan. So it would still be negotiable.

Mr. BIEBER. But under the plan, if I follow his question—under the plan, I think we agree, Gerry, and I agree with what he says. The cap ought to be the same. So far as the plan, what is provided by law, if the law says they have to provide 80 percent, the 20 percent would be negotiable. That would be true in the private sector as well. All we're saying is the same treatment ought to be there for the public sector.

Mr. REED. Thank you.

Chairman WILLIAMS. Fellows, thanks a lot for coming by. We appreciate your being here.

Mr. MCENTEE. Thank you. And we beat the rain, Mr. Chairman.

Chairman WILLIAMS. Yes, we did, indeed, Gerry.

I would ask the four witnesses of our second panel to come forward. Ms. Kolker, Mr. Wingate, Mr. Feltman, and President Chambers.

Mr. GREEN. Mr. Chairman, while the panel is coming up—Mr. Gunderson is concerned about price controls and global budgets, and I share his concern, but I also know that under our current system, there are price controls. You know, insurance companies have an amount they will pay. Now, sure you can go above that, but you have to make an extraordinary effort to show the need there.

So under the current system, we have price controls, and as a former hospital board member, we had a budget we had to live under during our year, and so if somebody has a budget, whether it's a global budget or a hospital budget or a State budget for health care.

Chairman WILLIAMS. All right. First let me apologize to this panel for—I guess it's not a true apology; you understand how it works, nobody's fault. Members have very tight schedules, and most of them stayed an hour and a half or so at this hearing. As you can see, a lot of them have left. Some of them may come back in.

We didn't realize we were going to have so many members here this morning, or we may have brought both of the panels together to the table or however we could have done it.

But we're sorry that we've delayed you so long and that some of the members had to attend other hearings and other meetings with their constituents.

Our first witness on this second panel is the director of government affairs with the National Women's Law Center, Ann Kolker. Ms. Kolker, thanks very much for being with us, and please proceed.

STATEMENTS OF ANN KOLKER, DIRECTOR OF GOVERNMENT AFFAIRS, NATIONAL WOMEN'S LAW CENTER; EDWIN WINGATE, SENIOR VICE PRESIDENT, PERSONNEL, DAYTON HUDSON CORPORATION; KENNETH E. FELTMAN, EXECUTIVE DIRECTOR, EMPLOYERS COUNCIL ON FLEXIBLE COMPENSATION; AND LETITIA CHAMBERS, PRESIDENT, CHAMBERS ASSOCIATES, INCORPORATED, AND EXECUTIVE DIRECTOR, PRE-MEDICARE HEALTH SECURITY COALITION

Ms. KOLKER. Thank you very much, Mr. Chairman. Thank you for the opportunity to testify before this committee on health care reform and its impact on workers and retirees. I am here today representing both the law center and the Campaign for Women's Health, where I cochair the legislative committee with the American Nurses Association.

You know about the law center from the kind remarks of Congresswoman Woolsey. Let me tell you a little bit about the Campaign for Women's Health. It's a broad-based coalition of 90 national, State and grassroots organizations convened to advance

women's health interests in health care reform, representing more than 8 million individuals nationwide.

It was established in 1991 with the goal of ensuring that women have a strong voice in the debate on health care reform, commensurate with our numbers. The campaign has developed a set of principles articulated in our full statement.

Today we will speak about the pressing needs of working women whose health care needs can most fairly be met through a reformed system that guarantees universal coverage, provides affordable health care, and ensures a comprehensive benefit package and access to a range of providers to meet women's specific health needs. These are key campaign and key law center principles.

I want to just start by reaffirming that the women's community strongly believes that there is today a real crisis in health care. As we know, there are tens of thousands of people who lose their health care monthly; people are caught in job lock; women's health care needs are very poorly met in some cases under current insurance practices, with preventive care particularly being ignored by many insurance companies.

And even when health care is available, it is often unaffordable for women who have to purchase it themselves or in the small business community.

The crisis affects women workers in many ways. Employed women are one-fourth less likely than men to receive health care coverage directly through an employer. Indeed, a mere 30 percent of employed women have health insurance coverage through their work, compared to 56 percent of employed men.

There are several reasons for this. Women are disproportionately represented in low-wage jobs. They are concentrated in the jobs paying under $20,000 a year, where virtually all the uninsured workers, close to 90 percent, are concentrated.

In addition, women are concentrated in the service and retail trade industries, which have the lowest rates of health benefits. For example, over one-half of all uninsured workers are employed in the female-dominated trade and service sectors.

Finally, women comprise over two-thirds of the part-time workforce, a group only one-third as likely to have health care coverage as full-time workers.

The employer mandate described in the Health Security Act, in the President's Health Security Act, takes an important step towards addressing the particular concerns of part-time workers because it requires employers to pay a pro rata share of the health care premiums for employees who work between 10 and 30 hours a week, defining full-time employees as 30 hours or more.

There are, however, problems for some part-time workers, particularly those who work less than 10 hours a week and those who work for multiple employers, that we will be happy to discuss in more detail.

In addition, women are much more likely than men to be insured as dependents, comprising 72 percent of those who rely on dependent coverage.

Each of these vulnerable populations that I have described would receive guaranteed coverage through either the single payer system

or the employer mandate as described in the Clinton plan, with the special provisions for part-time workers, as I discussed.

In addition, women on welfare risk losing their health insurance when they join the workforce. Health care reform has the potential to enhance the ability of many women who are dependent on welfare and receive health coverage through Medicaid to leave welfare for paid employment because welfare recipients often lack the training and qualifications for the types of jobs that provide health insurance.

As a result of women's concentration in low-wage jobs, as I have described, affordable care is crucial to women. With regard to the President's plan, because workers are required to pay a portion of the premium, the level of this contribution is key to affordability. Thus, we believe a generous employer contribution is critical and that anything less than the 80 percent share required by the Health Security Act could impose real hardship on working women and their families.

But even with the 80 percent contribution, some low-wage individuals may still need assistance to cover the cost of their health care coverage. Of course, the single payer plan is very strong in its affordability provisions, and the Health Security Act contains several critical provisions which will help ensure affordability, which we strongly support—the caps on out-of-pocket expenditures, the limitations on lifetime limits, community rating, and of course the premium subsidies for low-income working individuals.

We would like to add, however, that these provisions only provide the minimum protections to low-income individuals and we hope that there is a way of working with the committee to improve these protections, particularly looking at the copays for low-income individuals.

While universal affordable coverage is a necessary part of any health care reform, it's not sufficient, and these provisions mean little without comprehensive health benefits and access to a range of health care providers to meet women's unique, special health care needs.

We believe that there must be a guaranteed benefit package based on a broad standard to ensure a full range of services. This benefit package must be available to workers through both private and self-insured plans. The medically necessary or appropriate standard described in both the President's proposal and the single payer scheme would ensure broad-based coverage.

In addition, we believe that it is essential to have preventive care, the full range of reproductive health care services, long-term care, and mental health and substance abuse services as well, as they would with varying degrees of completeness in both the Health Security Act and the single payer plan.

We believe that the services covered under the Cooper plan are still undefined because this proposal shifts the responsibility for defining the benefits package to a national board, an observation that was made earlier. We cannot support a reform package without concrete assurances that women's health needs will be met.

Of course, reproductive health care is a critical part of this, and I want to underscore that. The law center did a report, which we

will make available to committee members, that describes the essential elements of reproductive health care.

Chairman Williams, in conclusion, we believe that women have gotten short shrift in our current system of health insurance, and the stakes for women in the health care reform debate are very high. We urge you to work to ensure comprehensive, affordable coverage with a guaranteed benefit package, and we look forward to working with you, Mrs. Roukema, and other members of the committee in the way that we did on the Family Leave Bill to assure that we reach this goal. Thank you very much.

[The prepared statement of Ann Kolker follows:]

TESTIMONY OF ANN KOLKER
ON BEHALF OF

THE NATIONAL WOMEN'S LAW CENTER
AND
THE CAMPAIGN FOR WOMEN'S HEALTH

BEFORE THE SUB-COMMITTEE ON LABOR-MANAGEMENT RELATIONS
COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES
ON
THE EFFECT OF HEALTH CARE REFORM ON WORKERS AND RETIREES

Chairman Williams and other members of the committee, thank you for the opportunity to testify before this committee on health care reform and its impact on workers and retirees. I am Ann Kolker, public policy director of the National Women's Law Center. I am here today representing both the Center and the Campaign for Women's Health where I co-chair the Legislative Committee with the American Nurses Association.

The National Women's Law Center is a non-profit organization, working since 1972 to advance and protect womens' legal rights. The Center focuses on major policy areas of importance to women and their families, including health care reform, reproductive rights, employment, education, family support and income security -- with special attention given to the concerns of low-income women and their families.

The Campaign for Women's Health is a broad-based coalition of ninety national, state and grassroots organizations convened to advance women's interests in health care reform and representing more than eight million individuals nationwide. The Campaign was established in 1991 with the goal of ensuring that women have a strong voice in the debate on health care reform, and one commensurate with our numbers.

Representing 52% of the population, women comprise the majority of health care consumers. Women are also the major health caregivers, whether employed as nurses, doctors, hospice workers and health educators, or as the unpaid caretakers of family members. Women's health is everyone's health.

Yet, more than 12 million American women have no health insurance of any kind. Many millions more have inadequate insurance with health services, such as preventive care, unavailable or so limited as to fail to assure women's most basic health needs. Moreover, in our employment-based system, access to health coverage is more limited for women than for men because coverage is determined by employment and marital status, two factors which unfairly disadvantage women. In myriad ways, women have been treated as second class citizens in the health care system, unable to access the health care services that will protect and promote their health. Health care reform is a critical moment to right the wrongs American women have endured for far too long.

The Campaign for Women's Health Principles

The Campaign has developed a set of principles, which the National Women's Law Center endorses, by which we measure whether a health care reform proposal will meet the health needs of women. These principles include:

- **Universal Access.** Every individual must be covered for health care services.
- **Equal Access.** The ability to pay, employment, health, age, marital and residency status must not be barriers to care. All women should have access to a single, high-quality standard to care.
- **Affordable Costs.** The cost of health care must be affordable, and cost-sharing in

the form of copayments and deductibles must not constitute barriers to care.

•**Comprehensive Benefits.** Comprehensive health services must include a full range of preventive, primary, reproductive health, and long term care services. A broad standard requiring all services which are necessary or appropriate for the maintenance of health must be established.

•**Choice of Providers and Settings.** Health services must be available from a range of providers, including physicians, advance practice nurses, health educators, and other allied health providers. Health services must be available in a range of settings, including hospital and outpatient settings, practitioner's offices, the home, and long term care settings. Services must be community based and transportation, child care, and financial assistance should be available.

•**Accountability.** Women must be part of the decisions made in the design and implementation of reform. Women representing a broad spectrum of the women's health community should be appointed to boards, commissions, and other advisory and regulatory bodies of a new health system.

We have been asked to speak today about the effect of health care reform on workers. Our testimony will focus on the pressing needs of working women, whose health needs can most fairly be met through a reformed system that guarantees universal coverage for all American women, provides affordable health care, and ensures a comprehensive benefits package and access to a range of providers to meet women's specific health needs.

While our comments reflect the need for health care reform generally, we emphasize the President's Health Security Act, with its employer mandate, as it is currently the

centerpiece of national debate. We will also refer, where appropriate, to some of the other models that have been proposed.

I. Our Current System Fails to Provide Health Security to Women and Their Families

Our current system of health care coverage is really a patchwork of several different systems:

-> 62.5% of nonelderly Americans have employment-based health coverage;

-> 15.1% rely on publicly-funded health insurance;

-> 8.5% purchase private insurance on their own; and

-> 17.4% -- almost 40 million Americans -- lack health insurance of any kind.[1]

Although the employment-based system covers the majority of Americans, it is far from adequate. Because our current system allows, but does not require, employers to contribute to the health care premiums of their employees, the security that health insurance provides continues to elude even many working individuals. The majority (52.4%) of the uninsured are in families headed by full-year, full-time workers.[2] Moreover, even those fortunate enough to have employment-based coverage are at risk of losing their insurance at any time due to employer cut-backs, or if they leave their job. In short, today's employment-based system fails to guarantee true health security, but health care reform which assures universal coverage either through an employer mandate or a single payer system could dramatically change that for many women. The Cooper proposal, however,

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[1] Employee Benefits Research Institute ("EBRI"), Sources of Health Insurance and Characteristics of the Uninsured, January 1994, at 5.

[2] Id. at 9.

which is based on a completely voluntary system, does not guarantee coverage, even to all working Americans. This approach is not much of a change from the system we have today.

A. Employed Women are Less Likely to Receive Employment-Based Health Insurance than Employed Men

Women are particularly vulnerable under our current system. They are one-fourth less likely than men to receive health coverage directly through an employer.[3] Indeed, a mere 37% of employed women have health insurance coverage through work, compared to 56% of employed men. The reasons for this alarming disparity are manyfold.

1. Women are Disproportionately Represented in Low-Wage Jobs

First, women workers are disproportionately represented in the jobs paying under $20,000 per year where virtually all the uninsured workers (88%) are concentrated. For example, nearly half of all working women earn under $10,000 and a full 80% of working women earn under $20,000 compared to half of men. By ensuring coverage to all employees, regardless of income, an employer mandate would constitute an important step toward rectifying the injustices women suffer by being relegated to low-wage jobs, where health coverage is so often lacking.

Similarly, a single-payer system would alleviate this problem for women by assuring coverage to everyone, regardless of employment status.

2. Women are Concentrated in the Service and Retail Trade Industries

Second, women workers are concentrated in the very industries which have the lowest rates of health benefits. For example, over one-half of all uninsured workers are

[3] Id. at 50.

employed in the female-dominated trade and service sectors. Service workers, 61.7% of whom are women, constitute nearly one-quarter of all uninsured workers. In retail trades, where more than half of the workers are women, 58.3% of workers receive health insurance through their employer. By contrast, in wholesale trades, where nearly 70% of the workers are male, employer-provided insurance covers nearly 80% of all workers. Any health care reform effort must rectify this inequity by ensuring coverage for this group of workers -- predominantly women -- who have been historically denied a benefit provided to many other groups of workers.

3. The Majority of Part-Time Workers are Women

Finally, women comprise over two-thirds of the part-time work force -- a group only one-third as likely to have health coverage as full-time workers. We must devise a system that does not leave this vulnerable population -- often unable to afford the costs of health care -- uninsured. A single payer system, with guarantees of comprehensive coverage for all, is one possible solution. Alternatively, part-time women and their families would benefit from an employer mandate such as that described in the Health Security Act which requires employers to pay a pro-rated share of the health care premiums for employees who work between 10 and 30 hours per week. Indeed, because the employer's pro-rata contribution is based on a 30-hour work week, the proposed scheme is particularly advantageous to part-time workers. For example, an employer would be required to pay 40% of the health care premium for an employee who worked 15 hours per week (15 hours worked/30-hour work week X the 80% share the employer is required to contribute for a full-time employee). Either this employer mandate or the single payer option would finally

make health care both available and affordable for many who work part time, although under the Clinton plan some part-time workers, particularly those who work for multiple employers, may have difficulty securing coverage.

B. Women Are More Likely Than Men to Be Insured as Dependents

Health care reform also provides the opportunity to help those who are in the precarious position of relying on dependent coverage, which has been cut significantly in recent years. Not surprisingly, many more women than men receive health coverage as dependents: women comprise 72% of those who rely on dependent coverage.[4] Individuals who are covered as dependents fall into two categories: those who work but whose employers do not provide health benefits, and those not in the work force. Guaranteed universal coverage would benefit both of these vulnerable populations.

* First, extending health care coverage to all Americans will enable the many working women whose employers do not now provide insurance benefits to secure coverage in their own right, and at the same time to obtain a sense of security they simply do not have when dependent on the employment-based coverage of a family member. Much more than a symbolic improvement, guaranteeing universal coverage will provide important protection against the risk of losing coverage when a spouse loses or changes jobs or in the event of a change in family status.

* Second, even those who are not employed would be guaranteed dependent coverage under the Health Security Act if they have a spouse who works. The Act provides for health care premiums to vary according to four family types: single

[4] Id. at 51.

individual, couple without children, single-parent family, and dual-parent family. Employers contribute to their employees' premiums based on the family status of the employee. For example, the employer of a married woman with children would pay 80% of the premium amount for a dual-parent family, thus contributing to the health care coverage of the entire family. By building dependent coverage into the employer mandate in this way, the Health Security Act will indeed provide health security to many who live in fear of losing their dependent coverage today. Moreover, the Act prohibits employers from discriminating against an employee on the basis of her or his family status[5] -- thus providing an added protection to employees with dependents. While commendable, these protections should be strengthened to prohibit discrimination by employers on the basis of an employee's sex, race, national origin, and any other protected status. While Title VII would cover discrimination in this regard for employers with more than 15 employees, clarifying the prohibition for all in the Act is important.

C. Women on Welfare Risk Losing Their Health Insurance When They Join the Work Force

In addition to providing health security to millions of Americans who are currently uninsured, health care reform has the potential to enhance the ability of many women who are dependent on welfare and receive health coverage through Medicaid to leave welfare for paid employment. The very structure of our health care system today serves as a

[5] Section 1605.

disincentive to getting a job and going off welfare. Often, welfare recipients lack the training and qualifications for the types of jobs that provide health benefits. As a result, they are forced to choose between taking a job without health insurance or continuing to rely on public assistance with the attendant health benefits. Just last week an article in the Wall Street Journal cited a study showing that "welfare caseloads would drop 25% if private health insurance that matches the comprehensive coverage of Medicaid were extended to all working women who head households."[6] Any health care reform approach that guaranteed universal coverage would do just that.

II. Health Care Must be Affordable

As described above, women are concentrated in low-wage and part-time jobs. In addition, women's earnings continue to equal a mere 70% of men's. As a result, affordable health care is crucial to women. With regard to the President's plan, because workers are required to pay a portion of the premium, the level of this contribution is key to its affordability. Thus, a generous employer contribution is critical. Anything less than the 80% share required by the Health Security Act could impose real hardship on many working women and their families, forcing them to choose between seeking needed medical care or having enough money for such basic necessities as food or rent.

Even with a system that requires employers to cover 80% of the cost of an employee's health insurance premiums, some low-income individuals may still need

[6] Birnbaum, Jeffrey H. and Frisby, Michael K., "Clinton Pledges that Crime and Welfare Issues will get Near-Equal Billing with Health Care," Wall Street Journal, January 26, 1994.

assistance to cover the costs of their health care. The Health Security Act contains certain protections for low-income people that are essential to making health care affordable to working individuals for whom health care costs are more than their meager salaries can afford. These important protections include:

* Caps on out-of-pocket expenditures -- Under the plan, out-of-pocket costs, such as deductibles or co-payments resulting from multiple visits, are capped annually at $1,500 per individual and $3,000 per family under all health care plan options.

* Elimination of lifetime limits -- The plan does not allow lifetime limits on coverage.

* Community rating -- Premiums are determined based on community rating, not the discriminatory gender-rating practice which forces women to pay more than comparably situated men. This rating principle follows the successful model of Montana where women's annual health insurance costs dropped by $1,103 after the state adopted community rating. The savings had a significant impact on low- to moderate-income women, including single parents. Before community rating, many of these women simply could not purchase insurance or were forced to rely on Medicaid.

* Premium subsidies for low-income working individuals -- Low-income individuals, who are disproportionately women, will be helped by two types of subsidies:

    1) Their share of the premium will be subsidized if their incomes fall below 150% of poverty, with subsidies greatest for individuals and

families below poverty, and phasing out between 100% and 150% of poverty. Those at poverty would expend no more than 3.0% of income on the employee share of the premium.

2) For families with adjusted income below $40,000, a 3.9% cap on the amount of income they must pay toward the employee share of their premium will help cushion them against steep costs. Their share of the premium may not even reach this cap, but the caps provide important protections in the event that actual premiums are much higher than the estimates.

While vital, the provisions in the Health Security Act provide only the minimum protections to low-income people. We look forward to working with you to improve these provisions, to ensure that health care is truly affordable for all Americans.

One oft-neglected group for whom affordability provisions are particularly important is those who are outside the labor force. Important as an employer mandate is, it benefits only those who are employed, neglecting those women whose income is derived from non-wage sources such as pension or alimony. The employment-based system is irrelevant for this vulnerable population, which is left to bear the entire burden of health insurance premiums on their own. As we work to create a reformed health care system, the special needs of those who will receive no employer contribution must not be overlooked.

III. The Need to Ensure Comprehensive Benefits and a Choice of Providers

While universal, affordable coverage is a necessary part of any health care reform package, it is clearly not sufficient. Universal coverage means little without comprehensive

health benefits and access to a range of health care providers to meet women's specific health needs. Health care reform provides a long overdue opportunity to remedy a system that historically has shortchanged women through its bias against preventive care, patchwork treatment of reproductive health care services, failure to reimburse for services obtained from nurse practitioners and other non-physician providers, and indifference to long term care and mental health and substance abuse treatment.

To adequately address women's health needs, there must be a guaranteed benefit package based on a broad standard to ensure a full range of services. This benefit package must be available to workers covered through both private and self-insured plans. The "medically necessary or appropriate" standard described in both the President's proposal and the single payer scheme would ensure broad-based coverage. In addition, it is essential to women that preventive care, the full range of reproductive health care and long term care services, and mental health and substance abuse treatment are covered. All of these services are covered by both the Health Security Act and the single payer plans with the later two covered more comprehensively by the single payer bill. The services that would be covered under the Cooper plan are still undefined because this proposal shifts the responsibility for defining the benefits package to a national board. The benefits package is to be determined after the legislation is passed and becomes law. We cannot support a reform package without concrete assurances that women's health needs will be met.

While all of the health services outlined above are vital to women's health, we want to spend a moment on reproductive health care as it is such a critical component of the health care women need throughout their lifetime. Because it is so crucial, it is often the first type

of care a woman seeks, and for many the only form of primary care they receive.

This summer, the National Women's Law Center authored a report entitled "Reproductive Health: An Essential Part of Health Care," which contains a complete discussion of the importance to women of reproductive health care. We have provided each of you with a copy of this report and ask that it be made a part of the record.

Women's reproductive health care includes pregnancy, delivery and post-natal care; contraception; abortion; infertility services; and treatment for reproductive tract diseases. These services are linked and inseparable. Both women and their health care providers view reproductive health services as part of a continuum, and they must be treated as such in the benefits package. With respect to abortion, its inclusion as part of medically necessary or appropriate reproductive services in a national health care package enjoys broad-based popular support, as demonstrated by a recent public opinion survey conducted by Celinda Lake for the National Women's Law Center and the National Council of Negro Women. Moreover, most private insurance plans commonly provide coverage for abortion services. According to Michael Chee, spokesman for Blue Cross of California, "This is not a new phenomenon. Private insurance has paid for abortion for quite a while." Thus, including abortion as a covered service is a continuation of current practice.

* * * * *

Chairman Williams, in conclusion, women have gotten short shrift in our current system of health insurance. Accordingly, the stakes for women in health care reform are

particularly high. We urge you to move forward to ensure comprehensive, affordable coverage with guaranteed benefits to all Americans as expeditiously as possible. We look forward to working with you to devise a system that truly provides health security to America's women.

NATIONAL WOMEN'S LAW CENTER

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REPRODUCTIVE HEALTH: AN ESSENTIAL PART OF HEALTH CARE

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EXECUTIVE SUMMARY

Reproductive health is a critical component of the health care women need throughout their lifetime. Because reproductive health care is so central to women, it is often the first type of care a woman seeks, and for many the only form of primary care they receive. Although the need is great, women encounter numerous problems in obtaining key services -- from a shortage of obstetricians and gynecologists to the failure of many insurance programs to reimburse for preventive screening. As a result, women's health, and the health of their children and partners suffer.

In spite of the inadequacies of the current system, some public and private programs provide solid coverage for women's reproductive health needs, demonstrating that it is feasible, practical and cost effective to provide critical reproductive health care services.

Abortion services are, for example, generally covered under private health insurance; an expansive array of maternal and infant health and family planning services for low-income women are supported by government programs; and support for both infertility services and treatment for sexually transmitted diseases has come from both the public and private sector. Taken together, these programs and policies provide useful models for meeting the reproductive health care needs of women.

I. The Reproductive Health Care Needs of Women

Women's reproductive health care needs, which cover pregnancy, delivery and post-natal care, contraception, abortion, infertility services and treatment for reproductive tract diseases are inextricably linked. Good reproductive health care not only enhances women's health, it confers health benefits to a woman's children and partners.

Family Planning and Contraceptive Care

- For 90% of her reproductive life, the average woman either wants to postpone giving birth or avoid having more births. For only 10% of her reproductive life is a woman actually pregnant or attempting to become pregnant.

- Family planning is cost effective - for every dollar invested in public family planning services, $4.40 is saved. Experts estimate that if all pregnancies were planned, infant mortality rates could be reduced by approximately 10% and low birth weight by 12%.

Pre-natal and Maternity Care

- Approximately 3.7 million women, about 7% of all American women of childbearing age, have a baby each year. Eight out of 10 women will have at least one child by the end of their reproductive years.

- Every dollar spent on prenatal care saves $3.38 in the cost of caring for low birth weight babies. Averting one low birth weight baby can save $14,000-$30,000 in first year hospital and long-term health care costs.

Abortion

- The risk of serious complications from a legal abortion is low, and most women who have an abortion experience few if any problems getting pregnant or having healthy children in the future.

- The average cost of an abortion is about $250. Legal abortion has been associated with important declines in U.S. maternal mortality rates.

Reproductive Tract and Sexually Transmitted Diseases

- Each year more than 12 million women and men contract a sexually transmitted disease ("STD"), but the consequences are often more severe and long lasting for women than for men.

- Every year prevention and early treatment of sexually transmitted diseases saves millions of dollars in direct health care costs and millions more in the indirect costs of lost wages and decreased productivity of affected individuals. Gonorrhea and chlamydia screening and education saved as much as $193.1 million in direct health care costs and as much as $153 million in indirect costs.

Infertility

- One in every six couples is infertile or fails to conceive within a year of deciding to have a child. Infertility is a treatable reproductive disease with 50% of infertile people treated, both women and men, able to conceive.

- Among couples seeking treatment for infertility, 85 to 90% can be treated through conventional medical/surgical procedures, rather than through more expensive procedures such as in vitro fertilization.

II. Problems in Obtaining Reproductive Health Care

Because women are particularly disadvantaged under our current health care system, they are often denied access to reproductive health care. In addition, provider shortages and limitations on critical services such as family planning and abortion deny many women coverage of these services even if they have certain forms of insurance coverage.

- Women and their children are disproportionately represented among the uninsured, creating devastating consequences for women's overall health.

- The problems in obtaining adequate reproductive health care services are particularly acute, because there is a shortage of obstetrician-gynecologists and a dramatic drop in the number of doctors trained and willing to perform abortions. As of 1990, 12.2% of ob-gyns nationally had given up obstetrics and 24.2% had decreased the level of high-risk obstetric care that they provided.

- Even when they have access to providers and some health insurance coverage, women can not count on receiving the full spectrum of reproductive health services. Many programs fail to cover Pap smears, but pay for expensive procedures once cervical cancer is diagnosed.

- Barriers to reproductive health care are particularly onerous for low income women. Obstetricians, for example, are one of the health providers least likely to accept Medicaid patients; the prohibition on medicaid-funded abortion has hurt the health and economic status of poor women, considering the cost of an abortion can be more than half the average monthly income of a family on AFDC.

III. Current Models of Public and Private Coverage.

Current public and private insurance programs provide some instructive models for a more comprehensive reproductive health care approach. These programs demonstrate that it is practical, feasible and cost-effective to cover the range of reproductive health care services in a national health care reform plan.

Family Planning and Contraceptive Care Coverage

- Medicaid, the single largest source of public funding for contraceptive services, provides a favorable 90% federal-state funding match for family planning services, including all approved contraceptives.

- Some private insurance covers the full range of family planning services. For example, plans offered by M.D. IPA and Kaiser Permanente provide explicit coverage of family planning services; other plans, such as those offered by Kaiser Permanente, Sanus and Group Care, provide explicit coverage of oral contraceptive drugs and devices.

Maternity and Pre-Natal Care Coverage

- The federal government has given special priority to the needs of poor, pregnant women. Medicaid coverage has expanded to include enhanced health services for pregnant women such as risk assessment, case management, perinatal education, nutrition counseling and home visiting.

- Employer-provided private insurance policies generally cover maternity care.

Abortion Coverage

- Private insurance plans have substantial experience in coverage of abortion. An informal survey conducted by the National Women's Law Center showed that major insurance carriers such as Blue Cross Blue Shields from selected states across the country, and other major carriers including Aetna, The Principal Financial Group and Employer's Health, commonly cover abortion services.

- A similar finding was recently disclosed in another informal survey conducted by The Los Angeles Times. Spokespersons for Kaiser Permanente and Pacificare confirm that it is their general practice to cover abortion as well.

- Abortion services are covered in the Hawaii state health plan, which has been widely identified as a useful model for national health care reform.

Reproductive Tract and Sexually Transmitted Diseases Coverage

- Screening and treatment of sexually-transmitted and reproductive-tract diseases are generally covered services under most public health plans, including Medicaid.

- Private insurance often covers the diagnosis and treatment of STDs and their complications.

Infertility Coverage

- Public funding for infertility services is provided under the Title X program. Services must include initial interview, education, examination, appropriate laboratory testing, counselling and referral.

- Most progress in covering infertility has come at the state level. Ten states, Arkansas, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, New York, Rhode Island and Texas require insurance companies to provide coverage for infertility services.

- Private insurance coverage of several major companies offers a wide variety of services for infertility, from testing to treatments.

IV. Conclusion

Comprehensive reproductive health care services are essential to address women's health care needs. Models from both public programs and private insurance demonstrate practical, cost effective and feasible ways of assuring women access to the full range of reproductive health care services they need and deserve.

REPRODUCTIVE HEALTH: AN ESSENTIAL PART OF HEALTH CARE

I. Introduction

Our nation's health care system is woefully inadequate to meet the health care needs of its citizens. Skyrocketing costs, coupled with limited or non-existent access to requisite health care services, have precluded many citizens from receiving basic health care. Although the United States spends more per capita on health care than any other country in the world, its infant mortality rate is among the highest in the industrial world, and 100,000 individuals a month continue to move into the ranks of the uninsured. Our country is the only advanced nation in the world that does not provide basic health care to all its citizens.

While general structural issues of access, coverage and cost-effective and affordable care have particular importance for women because of the limited coverage and economic means they now have, reproductive health care services epitomize key health needs which have particular importance for women. In the past, reproductive health services have been given little attention, resulting in devastating consequences for women as well as an adverse impact on men whose reproductive health needs are inextricably linked to those of women.

This document highlights the specific reproductive health care needs of women; discusses the range of services that address these needs; reviews the relationship of these services to women's health care and then offers models from public and private insurers which provide these services.

II. The Reproductive Health Care Needs of Women

Reproductive health care is a critical component of the health care women need throughout their lifetime. Moreover, such care confers health benefits to a woman's children and sexual partners. Because reproductive health care is so crucial, it is often the first type of care a woman seeks, and for many the only form of primary care they receive.

Women's reproductive health care includes pregnancy, delivery and post-natal care; contraception; abortion; infertility services; and treatment for reproductive tract diseases, which are the leading contributors to conditions such as infertility and cancer.

All aspects of reproductive health are inextricably linked. For example, the safe and effective use of contraceptives can greatly enhance women's health by enabling them to space

or limit their pregnancies. Likewise, the health of a pregnant woman, her baby, and her sexual partners can be severely compromised by reproductive tract infections and sexually-transmitted diseases that are left unchecked and untreated. Access to early abortion is far safer than childbirth, and for women carrying pregnancies to term, prenatal care not only leads to healthier babies, but also healthier mothers.

As the following information reveals, early prevention, diagnostic screening, education, prescription drugs, devices and treatment all combine to meet the panoply of women's reproductive health care needs.

Family Planning and Contraceptive Care

Family planning services, including access to contraceptive care, are essential to women's health.[1] For 90% of her reproductive life, the average woman either wants to postpone giving birth or avoid having more births. For only 10% of her reproductive life is a woman actually pregnant or attempting to become pregnant.[2] Of the 58 million U.S. women of reproductive age, 67% are at risk of an unintended pregnancy.[3] Accordingly, for the decades that span from adolescence to menopause, women require access to family planning services, including safe and effective contraceptive methods.

Effective family planning services and contraceptive care improve the health of women by assisting them to avert unintentional pregnancies, space their children and reduce the need for abortions. Further, some contraceptive methods can assist women and their partners in preventing transmission of sexually transmitted diseases. Moreover, family planning is cost effective; for every dollar invested in public family planning services, $4.40 is saved.[4]

Healthy children also depend on women receiving effective family planning services. Women who become pregnant unintentionally are more likely to have poor birth outcomes and are less likely to seek early prenatal care.[5] The National Commission to Prevent Infant Mortality estimates that if all pregnancies were planned, infant mortality rates could be reduced by approximately 10% and low birth weight by 12%.[6] Furthermore, a recent study by the Alan Guttmacher Institute concluded that avoiding birth intervals of less than two years could be expected to reduce by 5-10% the rate of low birth weight babies and the neonatal death rate.[7] Moreover, unwanted and unplanned children are at an increased risk for abuse and neglect.[8]

In many cases, women need an on-going relationship with their family planning providers in order to receive the necessary medical care to avoid an unintended pregnancy. Almost 13 million women of reproductive age obtain their family planning care in a doctor's office or HMO and 7.1 million women receive care in a clinic.[9] Of the women at risk of unintended pregnancy who use a contraceptive method, 13.4 million women use a reversible contraceptive method such as the pill, the diaphragm or the IUD, that at least initially requires medical supervision, including instruction on how to effectively use the drugs and devises.[10] It is

estimated that 25% of women do not properly utilize their contraceptive methods.[11] Without access to medical practitioners and clinics, women's contraceptive options remain limited and less effective.

Pre-natal and Maternity Care

Approximately 3.7 million women, about 7% of all American women of childbearing age, have a baby each year.[12] Eight out of ten women will have at least one child, and many will have had two or three children by the end of their reproductive years.[13] For many women, pregnancy and childbirth do not cause adverse health consequences of any magnitude. However, three in ten mothers are reported by their physicians to have had major health complications which can result in threats to the lives of both mother and child, adding considerably to the costs of medical care, and six of every ten mothers have some medical complications during their pregnancy.[14]

Prenatal care that begins early and continues throughout pregnancy can prevent low birthweight as well as infant mortality. Infants born to mothers who receive inadequate care are significantly more likely to die in infancy or be left with lifelong disabilities. According to a study by the Alan Guttmacher Institute, the infant mortality rate is 9.7 per 1,000 live births among newborns whose mother began prenatal care in the first trimester. It rises to 12.5 per 1,000 where care was initiated later in pregnancy. And it jumps to 48.7 per 1,000 cases where the mother obtained no prenatal care at all.[15] The high correlation between the absence of prenatal care and poor birth outcomes alone underscores the importance of this health service.

Many women, however, do not obtain prenatal care early enough, do not make enough prenatal visits, or do not get care throughout pregnancy. In 1988, for example, more than one million of the 3.9 million infants born that year had mothers who did not receive any prenatal care during the first three months of pregnancy.[16] Nearly 250,000 babies were born to women who received no care until the last three months of pregnancy or who received no care at all.[17] As a result, the risks of serious health consequences for the infant increase substantially.

In addition to affecting the health of the child, late or no prenatal care compromises the health of the mother. Late or no prenatal care leaves women without access to basic health services which permit detection and treatment of potential health problems or the opportunity to address such problems as use of drugs, alcohol, or tobacco during pregnancy. Women without prenatal care may go without necessary nutritional supplementation or access to highly specialized inpatient services. Without this access and care, pregnancy and childbirth become a risky experience for both mother and child.

Further, effective maternal health services are proven cost effective measures. Every dollar spent on prenatal care saves $3.38 in the cost of caring for low birth weight babies.[18] Averting one low birth weight baby can save $14,000-$30,000 in first-year hospital and long-

term health care costs.[19] The Special Supplemental Food program for Women, Infants and Children ("WIC") is also very cost effective. The health care and food supplements it provides to pregnant women, nursing mothers, infants and young children have produced savings of two to three dollars for every one dollar spent on WIC during pregnancy.[20]

Abortion

Abortion is a safe and effective procedure to terminate an unwanted pregnancy. The risk of serious complications from a legal abortion is low, and most women who have an abortion experience few if any problems getting pregnant or having healthy children in the future.[21] Increased physician education and skills, improvements in medical technology, and the trend towards earlier termination of pregnancy have only increased the safety of legal abortion. According to the American Medical Association ("AMA"), the risk of death due to a legal abortion is substantially lower than that associated with a pregnancy which is carried to term.[22] In 1985, for example, approximately nine women out of every 100,000 died during childbirth, a mortality rate more than 10 times as high as the abortion death rate.[23]

As medical authorities point out, abortion "is safest for a woman when performed early in pregnancy and by a well-trained, experienced physician working in a setting equipped to handle complications that might arise."[24] However, complications from legal abortion, physical or emotional, are now very rare.[25] The straightforward nature of the procedure is reflected in the fact that the average cost of an abortion is about $250.[26] Significantly, legal abortion has been associated with important declines in U.S. maternal mortality rates.[27]

Reproductive Tract and Sexually Transmitted Diseases

Sexually Transmitted Diseases

Each year more than 12 million women and men contract a sexually transmitted disease ("STD").[28] Women account for about half of all sexually transmitted infections that occur each year, but they suffer more frequent and severe long-term consequences than men.[29] For example, STDs can lead to pelvic inflammatory disease, infertility, cervical cancer, ectopic pregnancy, infant pneumonia and death, mental retardation, immune deficiencies and the death of infected individuals.[30] Untreated syphilis can enter the bloodstream and cause lung and heart damage and meningitis. The incidence of syphilis in the United States rose to its highest level in 40 years in 1989.[31]

The health risks of these diseases multiply when, undetected and untreated, STDs are passed on to a sexual partner or by a pregnant woman to her unborn child. Sizable portions of both women and men of all socioeconomic groups are exposed to the health risks of STDs through direct or indirect contact with multiple sexual partners. According to the 1988 National Survey of Family Growth and the 1988 and 1989 General Social Surveys, 67% of all women

aged 15-44 who have ever had intercourse have had more than one partner, 41% have had four or more, and 23% have had six or more.[32]

Every year prevention and early treatment of sexually transmitted diseases saves millions of dollars in direct health care costs and millions more in the indirect costs of lost wages and decreased productivity of affected individuals.[33] For example, gonorrhea and chlamydia screening and education saved as much as $193.1 million in direct health care costs and as much as $153 million in indirect costs.[34]

The advent of AIDS has markedly increased the awareness of the substantial threat of STDs. Women, particularly women of color, are the fastest growing HIV-positive group in the United States. Of the 1.5 million people who had been infected with the HIV virus as of September 1991, an estimated 300,000 to 400,000 of these were women and 19,796 had been diagnosed with AIDS.[35] Women who are diagnosed with AIDS tend to die twice as quickly as men with the same diagnosis, and 63% will die of HIV complications without ever having been officially diagnosed as having AIDS.[36]

Condom use is the best known way for sexually active women to avoid sexual transmission of HIV, the virus which causes AIDS. Experts stress that STD prevention and education efforts must include a discussion of AIDS as a disease which is transmitted largely through sexual contact. Since there is no known cure for AIDS, these education efforts are of major importance, particularly for those individuals who may engage in high-risk behaviors or are sexually active with partners who engage in such behavior.

Reproductive Tract Diseases

Reproductive tract diseases such as cervical cancer also threaten women's lives, although screening, early diagnosis and treatment can prevent the cancer from becoming invasive. Indeed, experts suggest that if women received regular Pap smears and diagnostic colposcopies when indicated, the incidence of death from cervical cancer would be significantly reduced if not eradicated. In the United States, cervical cancer causes over 4,500 unnecessary deaths among women each year, largely due to economic barriers in receiving a pap smear.[37] The American Cancer Society recommends annual pap smears for all women who are or have been sexually active or have reached age 18.[38] Early screening is equally important for breast cancer, which is the most common form of cancer in American women, affecting one in nine women in the course of her lifetime. Experts estimate that regular mammography screening which can detect breast cancer in its earliest, most treatable stage, can reduce mortality rates by 30%.[39]

Early detection of these diseases prevents other complications as well. For example, hysterectomy, the second most common major operation performed in the United States, is often the first course of treatment for a wide range of disorders, despite the fact that less radical and

less expensive treatments are very often available and effective. Moreover, hysterectomy sometimes becomes necessary because women fail to receive regular gynecological care which would detect uterine problems such as cervical cancer in time to prevent the need for such radical surgery.[40] The fact that women with incomes of less than $10,000 a year, those least able to afford preventive testing, are the most likely to have the procedure illustrates the serious consequences which result when primary care or routine screening is unaffordable or unavailable.[41]

Infertility

Over 2.3 million couples struggle with the disease of infertility.[42] One in every six couples is infertile or fails to conceive within a year of deciding to have a child.[43] Infertility is a treatable reproductive disease, with 50% of infertile people treated --- both women and men -- able to conceive.[44] Each year, close to one million couples seek medical advice or treatment for infertility.[45] The number of infertility-related visits to doctors has nearly quadrupled over the last 20 years.

This essential reproductive health care service, however, often requires several visits to the doctor as well as various tests, monitoring and treatment. A complete infertility diagnostic workup for a woman, for example, can take four or five menstrual cycles, with many of the diagnostic tests that can not be combined having to be scheduled at specific times in her cycle.[46] While the risk of infertility is one and a half times greater for African-Americans than for whites and is more common among people with less than a high school education, whites and those with higher incomes are more likely to pursue infertility treatment.[47]

Infertility is a curable disease that can be treated cost effectively. Among couples seeking treatment for infertility, 85-90% can be treated through conventional medical/surgical procedures, rather than through more expensive procedures such as in vitro fertilization.[48] Moreover, the cost of infertility diagnosis and treatment, when spread over the insured population, is relatively small. In Massachusetts, for example, policyholders paid $1.70 per family contract per month in 1990 to cover infertility.[49]

III. Problems in Obtaining Reproductive Health Care

Because women are particularly disadvantaged under our current health care system, they are often denied access to reproductive health care. For example, because of their lower earnings and concentration in service and retail jobs, which have low rates of employer-provided insurance, women and their children are disproportionately represented among the uninsured. Absence of health insurance has devastating consequences for women's overall health, denying them access to vital treatment or forcing them to miss prenatal care while pregnant. The failure of our health care delivery system to serve poor and rural areas takes a serious toll on many

pregnant women and their infants. Even when available, care for preventive service is often not a covered service, putting routine check ups and screening tests out of reach for many women.

The problem in obtaining adequate reproductive health care services is particularly acute, because there is a shortage of obstetrician-gynecologists and a dramatic drop in the number of doctors trained and willing to perform abortions. As of 1990, 12.2% of ob-gyns nationally had given up obstetrics and 24.2% had decreased the level of high-risk obstetric care that they provided.[50] In some states, the problem is worse than the national figures show. According to a 1990 report of western states, 39.7% of physician providers of obstetric services indicated that they had plans to leave obstetrics within the next year.[51] Seven out of ten of New York's family physicians, almost 40% of Texas family physicians and approximately one-half of Nevada's rural family physicians, have also stopped practicing obstetrics.[52]

Moreover, fewer doctors are trained and ready to perform abortions. More than one in four obstetrics and gynecology residency programs offer no abortion training, creating a severe shortage of physicians who can perform abortions.[53] Already, half of the nation's urban counties and 93% of local counties, where one third of American women reside, do not have an abortion provider.[54] The last North Dakota doctor who performed abortions retired in 1989, and in South Dakota and Montana there is only one physician in the state willing to accept abortion patients.[55] As the American Medical Association points out, as access to safer, earlier legal abortion becomes increasingly restricted, there is likely to be a small but measurable increase in mortality and morbidity among women in the United States.[56]

Even when they have access to providers and some health insurance coverage, women can not count on receiving the full spectrum of reproductive health services. In some instances both providers themselves and third party payers, private and public, have declined to provide or reimburse for family planning, contraception, abortion, and infertility services. For example, many publicly funded programs (and, often, private insurance plans) fail to cover pap smears, yet pay for expensive procedures once cervical cancer is diagnosed. In other instances, vital family planning and abortion services have been restricted by policy makers bowing to political pressure.

Barriers to reproductive health care are particularly onerous for low-income women because of limitations and inadequacies in the Medicaid program, the largest source of publicly funded health insurance. Obstetricians, for example, are one of the health providers least likely to accept Medicaid patients.[57] In recent years there has been a drop in Medicaid participation by ob-gyns and pediatricians. A 1987 survey found that only 63% of ob-gyns were accepting Medicaid, while the percentage of pediatricians accepting Medicaid dropped from 85% to 77% between 1978 and 1989.[58] As a result, adequacy of prenatal care varies according to accessibility - 81% of privately insured, but only 36% of Medicaid beneficiaries, and 32% of uninsured women receive adequate prenatal care. Finally, Medicaid does not cover single people in poverty or women who are poor and no longer have dependent children.

Additional obstacles have been placed on low-income women through limitations on abortion coverage. Prior to 1977, abortion services were available to Medicaid recipients in most states. Since 1977, however, federal Medicaid funding essentially has been non-existent despite the fact that the cost of an abortion can be more than half the average monthly income of a family on AFDC. Federal Medicaid funds may now be used for an abortion only if the life of the woman is endangered. Only 13 states continue to use their own revenues to provide all legally available abortion services for low income women. Clearly this decision is not based on cost factors. A state by state analysis reveals that for every tax dollar spent to pay for abortions for poor women, an average of four dollars is saved in public medical and welfare expenditures.[59]

Middle income women may have difficulty in obtaining critical reproductive health care services. Although the Pregnancy Discrimination Act generally mandates private employer coverage of pregnancy, for women insured through individual or non-employer-based plans, private insurance maternity coverage is sometimes spotty or limited, with riders or other special requirements not in place for other conditions. Women with private insurance may also be denied coverage due to a waiting period for preexisting conditions that include pregnancy. In fact, about nine percent of women of reproductive age, some five million women, have private insurance policies that do not cover maternity care at all.[60] These women are forced to rely on their own private funds or, if they qualify, to apply for Medicaid.

A shortage of providers and incomplete public and private insurance coverage, as well as a contentious political climate, deny many women coverage to basic reproductive health care. The rapid rise of sexually transmitted diseases, the limited scope of contraceptive options, and the lack of access to safe abortion services further aggravate the problem. Despite the central and crucial nature of reproductive health care, under our current health care system, American women have no guarantee of receiving the reproductive health care they critically need.

IV. Current Models of Public and Private Coverage

Our current patchwork of public and private insurance provides some instructive models for a more comprehensive health care approach. Despite the serious gaps in those who receive coverage and the coverage they receive, there are coverage models which have filled women's reproductive health care needs. They are described below.[61]

Family Planning and Contraceptive Care Coverage

The federal government has long recognized the importance of contraceptive services by providing funding for family planning services in several programs. Medicaid, the single largest source of public funding for contraceptive services, provides a favorable 90% federal-state funding match for family planning services, including all approved contraceptives. In addition, the federal government dedicates one federal program, Title X of the Public Health Service Act,

solely to these services. Each year over 3.7 million low-income women receive family planning services through Title X clinics. These clinics are frequently a woman's first and only entry point into the health care system, and as a result play a role far broader than providing contraceptive care alone.

This federal commitment is mirrored by the growing recognition among private insurers that family planning is an essential and cost-effective service. Emerging evidence suggests that there is an increase in private insurance coverage for the full range of family planning services, from pre-conception counseling to surgical sterilization. Private insurance plans offered by M.D. IPA and Kaiser Permanente of the Mid-Atlantic States offer examples of explicit coverage of family planning services, including counseling, genetic counseling, examinations, removal of devices and prescriptions for birth control methods. In fact, it is not unusual for private insurance to provide coverage for contraceptive drugs and devices. Many plans, such as those offered by Sanus and Group Care, provide explicit coverage of oral contraceptive drugs including the implanted time release contraceptive, Norplant, in addition to contraceptive devices such as diaphragms and IUDs. In other cases, health plans include family planning supplies in their general coverage of prescription drugs. Aetna HMO and Northwestern National Life provide examples of this approach. Moreover, some plans such as Kaiser Permanente and Blue Cross/Blue Shield, provide coverage for sterilization. This trend in private insurance demonstrates that private reimbursement for family planning services is becoming more common.

Maternity and Pre-Natal Care Coverage

In recent years, while far from meeting the need, Congress has given special attention to the need of poor, pregnant women. It has required expansion of Medicaid coverage for many poor women who would not normally be covered under their states' Medicaid program, and enhanced the health services for pregnant women to include risk assessment, case management, perinatal education, social services consultation, nutrition counseling and home visiting. When fully implemented, this expanded Medicaid coverage will serve more than 500,000 additional pregnant women and some four million children annually, making the program one of the largest sources of health care financing and services for maternity and child health coverage. The Maternal and Child Health Block Grant provides further federal funding to states for necessary pre and post-natal maternal care and maternal and child nutrition services. Finally, the Supplemental Food Program for Women, Infants, and Children (WIC) provides necessary nutrition counseling and food supplements in order to assist low-income pregnant and nursing women as well as infants and young children.

Most employer-provided private insurance policies cover maternity care since the Pregnancy Discrimination Act, an amendment to Title VII, requires employers with fifteen or more employees to cover pregnancy care in the same manner as they cover other services.

Abortion Coverage

Private insurance plans have substantial experience in coverage of abortion. An informal survey by the National Women's Law Center confirmed that major insurance carriers including a number of Blue Cross-Blue Shields from across the country as well as Aetna, The Principal Financial Group, and Employer's Health all report that they commonly provide coverage for abortion services.[62] Indeed, Michael Chee, a spokesman for Blue Cross of California stated, "This is not a new phenomenon. Private insurance has paid for abortion for quite a while."[63]

A similar finding was recently reached in an informal survey conducted by the L.A. Times. Spokepersons for Blue Cross-Blue Shield of California, Pacificare Health Systems, Inc., and Kaiser Permanente indicated that it is the practice of their companies to cover abortion services.[64] In conjunction with this survey, the Health Insurance Association of America and Foster Higgins & Co, one of the nation's largest health care consulting firms, maintained that abortion is "safe, proven, cost effective and worthy of insurance coverage."[65]

Insurance coverage for abortion services can also be found in some state health care plans. Hawaii, for example, has enacted a triad of public and private insurance programs to ensure universal access to health care for all its residents. The standard benefit package for each of Hawaii's three insurance programs provides coverage for surgical services for the termination of pregnancy.[66]

Reproductive Tract and Sexually Transmitted Diseases Coverage

Screening and treatment of sexually-transmitted and reproductive-tract diseases are general covered services under most public health plans. Physician, clinic and laboratory services for the diagnosis and treatment of STDs are explicitly covered under Medicaid. In addition to contraceptive services, Title X clinics provide a wide array of essential reproductive health care including screening for breast and cervical cancer, and STD and HIV services. Additionally, Section 318 of the Public Health Service Act provides authority for the Center for Disease Control to award grants to state and local health departments to provide STD prevention and control services. In FY 1986, for example, CDC project grants resulted in 7.4 million high-risk women being screened for gonorrhea as well as 147,000 receiving treatment.[67]

Private insurance often covers the diagnosis and treatment of STDs and their complications, subject to the usual deductibles, co-payments and other conditions imposed by private insurers. Testing for the HIV virus and AIDS normally would be covered under private health insurance if there is a reason to suspect illness unless excluded under restrictions preventing coverage of prior conditions. A study by the Office of Technology Assessment found that screening of individual applicants for insurance for HIV infection was quite common.[68]

Infertility Coverage

At the federal level, Title X provides public funding for infertility services by authorizing grants "to assist in the establishment and operation of family planning methods, infertility services, and services to adolescents." According to Title X program guidelines, grantees, at a minimum, must provide an initial infertility interview, education, examination, appropriate laboratory testing, counselling and referral. Although the federal Medicaid statute does not preclude coverage for infertility treatment, no state has paid for these procedures as of 1987. Some states have reported that they would pay for infertility procedures if a reimbursement claim was submitted.[69]

Most progress in covering infertility has come at the state level. Ten states, Arkansas, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, New York, Rhode Island and Texas require insurance companies to provide coverage for infertility services. These laws vary widely, from requiring insurers to provide 100% coverage of the diagnosis and treatment of fertility to requiring insurers only to offer coverage which the employer has the option to purchase.[70] Cost data available from states with infertility insurance mandates support the fact that the medical costs borne by an individual infertile couple are minute when spread across a large pool of insurance policyholders.[71]

Private insurance coverage offers a wide variety of covered services for infertility. Northwestern National Life's plan, for example, covers the full range of infertility services including diagnostic and therapeutic treatments. In a similar manner, the Guardian Life Insurance Co. of America's plan explicitly covers infertility services if a couple has been unable to attain a successful pregnancy through other means. The Health Insurance Association of America (HIAA) estimates that 40% of people covered under private insurance have coverage for some services related to infertility.[72]

V. Conclusion

Women have comprehensive reproductive health care needs which require comprehensive health care services. Pregnancy, family planning, contraception, abortion, sexually-transmitted and reproductive tract diseases, and infertility are not isolated and unrelated events, but inter-linked health care needs which require complementary and coordinated services. Coordinated and comprehensive reproductive health care services not only benefit women, but also confer benefits on men, children and families. Moreover, comprehensive reproductive health care is cost effective. The lessons of both public and private insurance models show conclusively that coverage for a broad spectrum of female reproductive health services is both feasible and affordable. The evidence amply demonstrates that providing comprehensive health care to women strengthens the health of our nation.

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Chairman WILLIAMS. Thank you. Our next witness is Edwin Wingate, vice president of Dayton Hudson Corporation. Mr. Wingate, thanks for being with us.

Mr. WINGATE. Thank you, Chairman Williams. I represent the Dayton Hudson Corporation. We are the Nation's 15th largest private sector employer, a general merchandise retailer with stores in 33 States, with about 180,000 employees, sales of about $20 billion a year.

My written testimony, which I know you have all had a chance to look through, outlines our support for health care reform, and therefore I will use this limited time describing probable adverse effects which we believe several of the proposals that you'll be considering would have on our employees and our retirees.

First, the administration's proposal would result in a single purchasing alliance in each geographic area of the country. Although it is offered, corporate alliances are not a practical alternative. None of the many companies with whom we talk would use them because of the financial penalties and the lack of subsidization of those programs, which you're aware of.

This lack of competition that would result on the purchasing side would discourage innovation and efficiency, resulting in wasteful costs. As all economic costs are in fact ultimately shifted to consumers, both employees of ours and of others and retirees of ours and of others would be the losers. Competition and market-based reform will work best, we believe, when there are multiple providers and multiple buyer groups.

Second, and from an equity and cost viewpoint, we want our employees in the 33 States we serve to be covered by essentially the same plans. The administration's position that each State would have considerable leeway in plan delivery and administration would affect that principle adversely, lead to administrative confusion, and add cost to delivery. This would subtract from the wages and benefits we would like to offer and would be prevented from providing. For these reasons, our company continues to strongly support continued preexemption under ERISA.

Third, certain concessions the administration has proposed to special interest groups would shift premiums and tax burdens to other employees, retirees, and employers. The most significant are, first, a 10-year moratorium on taxing of excess benefits and an estimated tax loss of about $25 billion a year. Dayton Hudson supports taxing of individuals and denying tax deductions for employers who provide such excessive coverages. This tax preference shifts directly costs to others, and it also encourages overuse of medical services.

Next, the administration plans to subsidize early retiree medical premiums. A limited number of companies have offered generous early retirement medical plans as a means of extracting other concessions. The administration's plan to subsidize 80 percent of these costs shifts an estimated $12.5 billion annually to other premium payers and taxpayers. In fact, early retirement arrangements do oppose declared public policy of encouraging employment beyond age 65 as evidenced by the Social Security entitlement program being moved from age 65 to age 68.

Fourth, we're concerned that the costs of the administration's reform proposal are understated and could therefore lead to much

higher premiums for employers and employees or major debt spending. Hewitt Associates, a nationwide actuarial firm which has testified several times before various committees, has estimated that the true cost of the administration's proposal would be about 25 percent greater than that which has been advertised. Details of this calculation are included in my outline and I know that they are also available from Hewitt Associates.

Several other objections are listed in the written statement, but I will close with comments on the financial effects that the administration's proposal would have on Dayton Hudson specifically and on retailing generally.

Retailing is a low-wage, low-profit-margin industry. We cannot afford the benefit costs that many manufacturing and high-tech businesses have adopted. The administration's plan, if enacted today, would increase our medical costs by 60 percent, from $110 million to $175 million per year. Were we to incur such increases, we would have several alternatives.

First of all, if we dealt with that cost through reduction of employees, we would have to reduce our employment by 15,000, nearly 9 percent of our workforce. Thirty percent of our workforce is in California, and that State would be exceedingly hard hit.

Or we can reduce earnings and therefore reduce shareholder value by about $600 million to offset that cost. As many of our employees and many of our retirees are shareholders, as many pension plans hold our shares, we believe that there would be a price paid there also.

We could offer lower wages and benefits in the future. In fact, that's the thing that many economists predict, including the Brookings Institute here in town. And we could of course use a combination of those alternatives.

These same issues and alternatives would be faced by all other food and non-food retailers. And I'm sure you are aware that about 20 percent of the U.S. population that's working is engaged in retail and non-retail trade, about one in five workers.

These are our major concerns. I have listed others in the written report. But I underscore that we are advocates of reform, we appreciate, we admire the work you're doing, and we are grateful for the chance to be here to describe some of the issues we're concerned about. And we'll be as cooperative as we can as this process goes forward. And so thank you very much, Chairman.

[The prepared statement of Edwin Wingate follows:]

Testimony on Health Care Reform

by Edwin H. Wingate
Senior Vice President, Personnel
Dayton Hudson Corporation
Minneapolis, Minnesota

February 2, 1994

Dayton Hudson Corporation is America's fourth largest general merchandise retailer. We operate nearly 900 discount and department stores in 33 states under the names of Target, Mervyn's, Dayton's, Hudson's and Marshall Field's.

We are the nation's 15th largest employer in the private sector with about 180,000 employees and sales of $20 billion per year.

For the past four years, Dayton Hudson has been an active supporter of nationwide health care reform. I am pleased to have this opportunity to present to your Subcommittee several reform areas which we support and others which we oppose. I will place special emphasis on those areas that are under the jurisdiction of your Subcommittee.

Briefly, we favor:

- Medical coverage for all Americans under a federally defined basic health care benefit package, with emphasis on prevention and primary care

- Subsidization of premiums for the poor and near-poor

- Policies which would contain cost increases at the CPI level (adjusted to the aging of the population), including:
  - Continuation of an employer-based system
  - Multiple purchasing alliances in each geographic area
  - Vertically and horizontally integrated medical delivery systems which would focus on Continuous Quality Improvement (CQI) and outcomes-based medical practice
  - Development of a national program for technology assessment and dissemination
  - Incentives for increasing the supply of primary medicine physicians and for providing medical services to under-served geographic areas
  - Consolidation of various forms of medical coverages (Workers Compensation, Medicaid, Medicare, auto insurance medical, etc.) into a single, nationwide system of benefits.
  - Elimination of cost-shifting from public to private payers
  - Administrative, tort, insurance and malpractice reform

- Financing of subsidies through sin taxes (alcohol and tobacco), taxes on excess benefits to individuals and non-deductibility of excess benefit costs for corporations and through quantified savings from reforms

- Government, business community and individual focus on improvement in lifestyle as it relates to mental and physical well-being

While we support national reform, Dayton Hudson Corporation has great concern over many of the specific reform proposals being considered by the Congress, including:

- **Lack of a competitive environment on the buyer side**

  The Administration's plan would create a single purchasing alliance in each defined geographic area. The offering of corporate alliances is not meaningful as the penalties for forming corporate alliances are prohibitive. Dayton Hudson has asked each of the major employees in our service areas if they would create an alliance if this plan were enacted. All have responded that they would not.

  We strongly believe that the market place will do a better job of holding down medical care cost inflation and overuse if corporations continue to have the ability to form individual and coalition buying groups (without penalty of financial disincentives). Competition will work best if there are multiple provider groups and multiple buyers.

- **Risk of loss of pre-exemption under ERISA**

  Dayton Hudson is a national retailer with operations in 33 states. We believe a standard set of benefits should apply to all states, and that individual states must not have authority to mandate benefits beyond that set level. For obvious reasons, we want all our covered employees to have essentially the same benefits and avoid having 33 different plans to manage. Furthermore, a diverse set of state by state plans would be counterproductive in the effort to bring about administrative simplification.

- **Costly concessions to special interests**

- The Administration's ten-year moratorium on the taxing of "excess" benefits (benefits that exceed the expected defined benefit package) would perpetuate cost-shifting. Such a moratorium is a subsidy to an over-benefitted individual and a cost to all who do not have this tax-free concession. Beyond that, such a subsidy is an inducement to providers to perform costly, unneeded medical procedures and to individuals to seek excess treatment. Dayton Hudson also believes that employers providing such excess benefits should not be allowed a tax deduction for such excess costs.

  The annual tax recovery that would result from closing this loophole is estimated at $25 billion per year, or a present value of over $200 billion.

- The proposed subsidy to early retiree medical premiums is another costly special interest concession.

  As part of their employment offer and for reasons they alone know, many corporations (particularly those with high seniority, high pay, hourly employees) have offered rich early-retirement arrangements to induce pre-age 65 retirements. Such arrangements have often included 100% company-paid medical coverage. These arrangements were not made for altruistic reasons but were typically made in return for concessions to the granting company.

The Administration's plan contemplates eliminating most of these obligations, and has estimated the cost of this concession to be $6 billion per year, which at a 6% discount rate has a present value cost of $86 billion. The General Accounting Office estimates the annual cost to be closer to $9 billion per year, or a present value cost of $129 billion. A recent Hewitt Associates study indicates a $12.5 billion annual cost or present value of $179 billion.

If such subsidy occurs, employees and employers would have further incentive to effect retirement before age 65 (opposing public policy of encouraging employment beyond age 65 as evidenced by the increased age for Social Security benefits), increasing further the cost of this subsidy.

- **Concerns related to financing**

First, Hewitt Associates, a nationwide employee benefits and actuarial firm, testified before the House Subcommittee on Health and Environment on November 22, 1993, that the Administration's cost estimates for their proposal are significantly understated, as follows:

Category Covered	Administration Average Plan	Hewitt Associates Estimate	Percentage Increase
Single adult	$1,932	$2,440	+ 26%
Two adults	$3,865	$4,880	+ 26%
Adult+children	$3,893	$4,610	+ 19%
Family	$4,360	$6,946	+ 59%

(NOTE: The text of the Hewitt Associates testimony is available by calling Hewitt's Washington, DC office (202) 331-1155.)

Second, long-term care as proposed by the Administration is additional cost which we oppose being included at this time. We should first reform and assure that we can manage cost inflation in the acute care system before we take on a burden which is neither fully understood nor predictable in its cost implications.

Third, our company would be severely affected by the Administration's financing proposal.

As a general rule, large industrial companies with skilled and semi-skilled full-time workforces have offered richer, more heavily subsidized medical plans (often providing 100% of medical care premiums for employees and dependents) than have low-margin retail and service industries. Additionally, and for competitive reasons, most service and retail companies have provided limited or no medical coverage for part-time employees (generally those working less than 24 hours per week).

Dayton Hudson's situation is representative of what food and non-food retailers would experience if the Administration's plan were implemented today.

Dayton Hudson employs about 180,000 people, and has an annual payroll of $2.2 billion:

- 105,000 of our employees are eligible for medical coverage. Only 65,000 have elected coverage.
- 40,000 of our employees who are eligible for coverage have declined coverage. (Either they are covered elsewhere or they have elected to be uninsured.)
- The company pays 65% of the premiums; employees pay 35%.
- 75,000 of our employees (most of our part-timers) are not offered medical insurance.
- Our company's 1993 medical costs were about $110 million.

If we suddenly had to pay premiums equal to 7.9% of payroll, rather than the current costs, insure the 40,000 eligibles who have chosen not to be covered at work, and also insure the 75,000 part-time employees, our annual cost would increase by 60%, from $110 million to $175 million, -- a $65 million increase.

How could we absorb this expense? Here are the alternatives:

- **Reduced Profits**

With 75 million shares of common stock outstanding, we could simply reduce earnings per share by 54¢. At this level, 1992 earnings would have been reduced from $4.82 per share to $4.28 per share. That earnings reduction would reduce our stock value by at least $8 per share (using a 15 multiple price earnings ratio).

High percentages of our shares are held by pension funds and other funds that underpin retirement income of large numbers of individuals.

- **Reduced Employment**

Like most retailers, we already have "downsized" our employment to the point that we are not able to give our customers the services we would prefer to provide. However, in an effort to tolerate a $65 million increase in costs, we might have to reduce our payroll costs significantly. To achieve that level of recovery from part-time employment, the reduction would amount to 15,000 jobs, or 20% of our 75,000 part-time employees. Among the 33 states we serve, our employment in California would be most heavily affected, as nearly 30% of our workforce is in that state.

- **Lower wage and benefit increases in future years**

- **A combination of the alternatives listed above**

If an employer mandate occurs at any significant level, a lower rate of employer contribution and a long-term phase-in based on promised and achieved containment of health care costs should be employed.

CONCLUSIONS

The case for health care coverage for all Americans, quality improvement, and cost control has been made. We believe an employer-based system is the appropriate approach to coverage. The question is: how far and how fast can we go in meeting the need, and how much regulation can be imposed without damaging our economy or given segments of it.

As the Congress and the nation work toward coverage, quality improvements and cost control of medical delivery, we must avoid unaffordable concessions, premiums and taxes on the one hand, and deficit spending on the other. We must also allow buyers and providers to operate in a competitive environment. Phase-in of coverages and costs, less costly standard plan provisions, higher participation in costs of coverage by individuals, and elimination of special interest concessions may all be necessary.

Dayton Hudson representatives look forward to a continuing participation in the development of nationwide reform. We thank you for this opportunity to testify before your Committee and we welcome the opportunity to discuss further our concerns and ideas with members of Congress and with their staffs as the debate continues.

# # #

Chairman WILLIAMS. Thank you, Mr. Wingate. The next witness is Mr. Kenneth Feltman, who is executive director of the Employers Council on Flexible Compensation. Thanks for accepting our invitation.

Mr. FELTMAN. Good afternoon, Mr. Chairman. My name is Ken Feltman, and I am executive director of the Employers Council on Flexible Compensation. The more than 700 members of our association are corporations, governments, unions, universities, hospitals and clinics, and the leading actuarial, insurance, and accounting firms that design and administer flexible benefits plans. Our members offer choice in benefits to over 14 million workers and their families.

This morning I would like to touch on three concerns. First, we fear the proposal is a step backward to a time of one-size-fits-all health care insurance where employees will have little if any real choice in the selection of their benefits.

Second, by removing health care from the menu of flexible benefits that employees can receive, the administration's plan will discourage the continuation of non-health care benefits, such as dependent care.

Finally, we believe that the plan rewards those employers who have done a poor job of managing their health care coverage and penalizes those who have done a good job of holding down costs. In essence the administration's plan is a bailout that should make Lee Iacocca or the savings and loan industry blush.

Flexible plans are popular with employees and cost less than traditional plans. By allowing employees to choose the benefits they really want and need and improving the efficiency of benefit use through increased awareness of benefits' costs, employers are able to limit the total cost of benefits and save money.

Many employers add wellness incentives to their plans. Some give extra credits or additional savings for employees who participate in fitness or, for example, smoker cessation programs. The rigid, topdown nature of the administration's plan, however, could cause us to lose the advantages of flexible plans—employee participation, choice, awareness, and cost control.

The administration claims its proposal provides real choice, but that simply is not the case when you compare it with most flexible plans in existence today. It's as if you were told you could buy a sedan, a fully loaded four-door sedan of your choice, and were given what is really a comparable car, perhaps offered by Ford, Chrysler, General Motors, and Toyota. But what if you need a station wagon? Perhaps you're single; you would like a sporty convertible. Perhaps you would like to save money and forgo the CD stereo or the power windows. Employees will find that they are paying for benefits that they do not want and may never use.

Flexible plans provide a wide range of non-health care benefits as well, and the advantages of cost containment and employee popularity apply to these non-health benefits as well as to health benefits. Many two-wage families have one spouse who will opt out of the health care portion and use those benefits to buy dependent care for the children or an aging parent or to put into retirement savings. Removing health care from the menu could destroy many

flexible non-health benefits as well. The two-earner family especially will have less flexibility.

Progressive, forward-thinking employers have learned that saving health care dollars results in a competitive marketplace advantage for their products and services. They believe that they can do a better job of managing benefits than the government. Few are eager to turn their health care responsibilities over to the government.

Many of these employers have failed to manage health care in a free market system, and they suffer competitively as a result. By reducing their liability from, say 18 or 20 percent, to under 8 percent, these employers will realize an unprecedented windfall under the administration's proposal. And that bailout will come at the expense of their workers and their competitors.

For years since we were founded in 1981, the Employers Council has fought for meaningful health care reform that will expand coverage to the uninsured, reduce costs for employers, and reduce costs for employees as well. But to solve these urgent problems may not require that we create new problems for those who now have quality care and affordable insurance. Thank you.

[The prepared statement of Kenneth Feltman follows:]

ecfc

Employers Council on Flexible Compensation
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STATEMENT OF

KENNETH E. FELTMAN, EXECUTIVE DIRECTOR
EMPLOYERS COUNCIL ON FLEXIBLE COMPENSATION

BEFORE THE
HOUSE SUBCOMMITTEE ON LABOR MANAGEMENT RELATIONS

FEBRUARY 2, 1994

Good morning, Mr. Chairman and members of the subcommittee. My name is Kenneth Feltman, and I am executive director of the Employers Council on Flexible Compensation. The Employers Council is a non-profit membership association committed to the study and promotion of 401(K) plans, cafeteria plans, and other elective compensation. The more than 700 members of ECFC are plan sponsors, corporations, governments, unions, universities, hospitals and clinics who are leading the way in the development and refinement of cafeteria and 401(K) plans and the leading actuarial, insurance and accounting firms that design and administer flexible plans. ECFC members offer choice in benefits to over 14 million workers and their families.

I would like to thank the committee for providing us this opportunity to discuss the concerns employers share over the Health Security Act of 1994, the Clinton Administration's health care reform proposal.

This morning I would like to touch on three of those concerns. First, we fear the proposal is a step backward to a time of one-size-fits-all health care insurance where employees will have little if any real choice in the selection of their benefits. Second, by removing health care from the menu of flexible benefits that employers can offer, the Administration's plan will discourage the continuation of non-health care benefits such as dependent care. Finally, we believe that the plan rewards those employers who have done a poor job of managing their health care coverage, and penalizes those who have done a good job of holding down costs. In essence, the Administration's plan is a bail out that would make Lee Iacocca or the savings and loan industry blush.

A great deal of choice has been promised in the Administration's plan, but for about one in four American workers employed by medium and large-sized businesses, it will mean less, not more choice. That's because they are covered by health care plans where employees enjoy a degree of choice in the selection of health care benefits options. Under these plans, known as cafeteria plans, an employee can opt for simple catastrophic coverage, for a larger or smaller deductible, for supplemental benefits to cover special needs, etc. Those who choose less expensive options pay less in coinsurance or deductibles, those who need

more pay more. But the important point is that employers and employees together design plans to fit their particular needs.

Over the past twenty years, 250,000 employers have turned to flexible plans because they are popular with employees and cost less than traditional plans.[1] By allowing employees to choose the benefits they really want and improving the efficiency of benefit use through increased awareness of benefits cost, employers are able to limit the total cost of benefits and save money.[2] While average annual medical claims costs for all employers rose about 15 percent in 1992, costs for those with flexible plans rose only 11 percent.

To reduce claims costs further, many employers have added wellness incentives to their plans in recent years. Some give extra credits or additional savings for employees who participate in fitness programs and health risk appraisals. Smokers who join cessation programs receive credits they can use for other benefits, time off and even cash in some companies.

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[1] In a 1993 survey of 472 employers by Hewitt Associates, 89 percent said they offer flexible benefits to meet diverse employee needs. Sixty-nine percent cited medical cost management as a key objective. *Business Insurance*, January 18, 1993. Page 26-27.

[2] As health care costs have risen, employee awareness has become a high priority for many employers. A Hewitt survey found that 62 percent of employers say they offer flexible benefits because they want employees to understand the value of their benefits. "New Priorities for Flex Plans," *Business Insurance*, January 18, 1993.

Unfortunately, the Administration plan completely ignores the benefits of flexible health care plans, and would totally destroy employee choice as we know it today. The rigid, top-down nature of the Administration's plan will lose the advantages of flexible plans: employee participation, choice, awareness and cost control.

All approved health care plans under the Administration's proposal, whether administered by a state, a large employer or by a purchasing cooperative, will be required to provide a single comprehensive set of basic benefits. These benefits will be determined by a new federal agency, the National Health Board, and will be standard nationwide. Employees may supplement their benefits with certain options, for which they will pay extra. Employers will be discouraged from helping employees with supplemental or additional coverage; any such employer contributions will be considered taxable income to the employee.

The Administration claims its proposal provides real choice, but that's simply not the case when you compare it to the many flexible plans in place today. All the Administration plan provides the employee is a choice among vendors, with the option to obtain certain supplemental coverage, not a real choice among benefits. It's as if you were told to buy a fully loaded four door sedan and the "choice" you were given was between comparable models offered by Ford, Chrysler, General Motors or Toyota. What if you need a station wagon? Or perhaps you're single, and you would like a sporty two-seat convertible?

Perhaps you'd like to save some money and forego the CD stereo or power windows? As in traditional, "one-size fits all" health insurance plans, under the Administration's proposal employees will find that they are paying for benefits they do not want and may never use. Should employees need coverage beyond what is provided in the basic plan, they will have to pay for it themselves, perhaps with after-tax dollars.

In addition to health care benefits, many flexible compensation plans provide a wide range of non-health care benefits as well. The advantages of cost containment and employee popularity apply to non-health as well as health benefits. As employers applied the cafeteria plan concept to retirement, dependent care and other benefits, the integrated flexible spending account has evolved. Based on certain factors -- age, income, family status -- employees receive benefits credits which they can apply to a wide range of options. Employees then can "spend" the credits as they wish. The most popular are retirement plans, dependent care, long term care, life insurance, legal services, extra vacation time and even cash. In many two-earner families, one spouse opts for family health care coverage while the other uses benefits credits to buy dependent care for the children or retirement savings.

By removing health care -- the centerpiece of most benefits plans -- from the menu of flexible benefits available to the employee, the Administration will destroy many employer-provided flexible non-health benefits as well as flexible health benefits. If an

employee can no longer trade between health and non-health benefits, his options will be limited dramatically. In two-earner families, both will have to pay a portion of health care costs, and the family will have less flexibility. Should employers perceive that demand for non-health benefits such as dependent care is declining, they may cease to offer them altogether.

Mr. Chairman, perhaps the greatest inequity in the Administration's plan is the incredible windfall it will provide a handful of large employers at the expense of the rest of the nation. The fact is that some employers have done a much better job than others in managing health care benefits successfully, regardless of the business they are in or the demographic make-up of their workforces. Progressive, forward-thinking employers have learned that saving health care dollars results in a competitive marketplace advantage for their products and services, and they have learned that they can save significantly without compromising quality. Indeed, every recent innovation in the field of health care coverage -- cafeteria plans, self-insurance, worksite wellness programs, managed care, and managed competition -- are a direct result of creative employers finding new ways to manage employee health benefits.

The Administration's proposal will remove the employer completely from the picture as a force for innovation and cost control. No longer will employers have any incentive to reduce costs and manage the quality of care because the government will take over these

functions. Most employers would prefer to retain a measure of control over the design and administration of their health care plans if they are going to continue to pay the lion's share of the cost of the plans. They believe that they can do a better job of managing benefits than the government. Because it is their dollars at stake, they have an incentive to control costs that cannot be expected to exist in a government-run bureaucracy. Because it is their employees at stake, employers care about the quality of coverage, claims administration, employee education and all the other administrative functions that will be turned over to the government under the Administration's plan.

Consider the prospects for worksite wellness programs under the Administration's plan. More than three out of every four workplaces in the United States today offer some kind of health promoting activity to employees, according to a recent survey by the U.S. Public Health Service.[3] Physical fitness facilities, nutrition and weight control, stress management, pre-natal care, back care and blood pressure control programs are among those offered by an increasing number of companies who have a financial incentive to prevent expensive health claims. A 1991 survey of private employers by the magazine *Business & Health* found that 57 percent of those who implemented wellness programs did so because "the cost is worth the benefit."[4] Under the Administration's proposal, employers will no longer realize any health insurance savings from worksite wellness

[3] 1992 National Survey of Worksite Health Promotion Activities. U.S. Department of Health and Human Services, Public Health Service. See pages 3-6.

[4] z'The 1991 National Executive Poll on Health Care Costs and Benefits." Business & Health, September 1991, V9 n9, page 60.

programs. Without a direct financial incentive, either through reduced risk if they self-insure or reduced rates if they commercially insure, many employers will likely curtail or terminate expenditures for worksite wellness.

Though most employers would like to retain control over the management of health benefits, a few are eager to turn their health care responsibilities over to the government. Many of these employers have failed to manage health care well in a free market system, and they are suffering competitively as a result. Some large employers have negotiated contracts with their workers' bargaining units that require them to pay as much as 20 percent of payroll for health benefits. By reducing their liability from 20 to 8 percent, these employers will realize an unprecedented windfall under the Administration's proposal, a bail-out that will come at the expense of their workers and their competitors. It's no wonder that some of these employers are lobbying hard for the Administration's proposal.

Health care reform is necessary. For years, the Employers Council has fought for meaningful reform that will expand coverage to the uninsured and reduce costs to employers and employees alike. Now, we confront a proposal that leaves us few options. Should the Administration's plan be adopted, we will destroy an entire system of employer-provided benefits, a system that, though far from perfect, still provides the best

health care on earth to the vast majority of American families. The system that will replace it may -- or may not -- work as well.

However, we can be sure of several things. Employees will have no real choice among the benefits they pay for and receive. Employers will have no motivation to control costs and little incentive for employee wellness. And few companies will get from the government what they failed to get in the free marketplace -- relief from health care costs.

Thank you.

Chairman WILLIAMS. Thank you. Our final witness on this panel is Letitia Chambers, who is president of Chambers Associates and executive director of Pre-Medicare Health Security Coalition. Ms. Chambers, thanks for being with us.

Ms. CHAMBERS. Thank you, Chairman Williams, Representative Roukema. I am appearing today on behalf of a broad-based coalition of unions, corporations, State and local government organizations, and aging and other public interest groups. A list of those participating in the coalition is attached to the back of my testimony.

This group is concerned with the health care coverage of a segment of our society that could easily fall through the cracks in health reform, those aged 55 to 64, who are no longer in the workforce or are unemployed, but are not yet eligible for Medicare.

Many persons in this 55-to-64 age group, the pre-Medicare population, do not have secure health coverage. In America today, we have an employer-based health system which the President proposes to expand. In an employer-based system, it is unfair to discriminate against those who are not working, particularly older persons who are displaced, unable to work, underemployed, or retired.

To advance the goal of universal coverage, health care reform must assure health coverage for non-working Americans age 55 to 64. Workers in this age category are vulnerable to being laid off or displaced and losing health benefits. Older workers who lose their jobs during corporate downsizing or restructuring often have great difficulty becoming reemployed. Such workers consequently leave the workforce entirely at much higher percentages than younger workers who are laid off.

According to CBO, over one-half of displaced workers over age 60 and over one-fourth of displaced workers between the ages of 55 and 59 leave the labor force. The sad thing is the fact that these displaced older workers become retirees not by their own choosing, but because of the lack of labor force mobility for individuals in this age range.

Also persons in jobs requiring physical labor, jobs that are filled disproportionately by minority members, are especially vulnerable to job loss as they age. Because minorities die at younger ages statistically, this population faces a kind of double jeopardy: crucial years before age 65 with no coverage or inadequate coverage, and then, due to a lower life expectancy, they don't live to receive the Medicare benefits that they earned in their working years.

Older workers are also susceptible to job lock. Fear of reduced health care coverage and poor job prospects for older workers keeps them from changing jobs, which impairs upward labor mobility for younger workers and may lower overall productivity.

More than one-fourth of the 21 million Americans age 55 to 64 are not working, and many of these have no or inadequate health care coverage. Most of them receive no health care benefits from their former employers. That's one of the misconceptions about this provision in the President's bill. Most workers in this category who have left the labor force have no employer-provided coverage. An estimated 2.7 million people in this age group were totally uninsured in 1992.

The General Accounting Office estimates that 96 percent of America's employers offer no health benefits to retirees. A national survey shows that companies are steadily reducing or eliminating such benefits. And for those that do offer such coverage, the competitive situation that they then face has led most of them to consider future reductions.

The competitive position that global competitors—facing companies in countries that pay for their retirees through a tax system and not through employer-based systems leaves these companies that are more progressive at a severe disadvantage.

There have been a lot of misconceptions also about the budgetary impact of the President's proposal. The cost of this provision is $11.6 billion through the year 2000. This cost is fully offset through the budget period by an assessment on those employers who now are offering retiree health benefits. There would be a cost associated beyond the budget period, that is, after 2001. But until that time, the cost is more than fully offset by the special tax.

In conclusion, Mr. Chairman, Federal coverage of the employer share, in essence, for the non-working pre-Medicare population is an important aspect of providing universal coverage. The beneficiaries of this provision include the individuals who are uninsured or who are underinsured and who will gain coverage, as well as those individuals now covered who will gain the security that they will not lose the coverage that they have.

The economy as a whole will also benefit through increased labor mobility and productivity and improved competitiveness of U.S. companies. The Pre-Medicare Health Security Coalition recognizes the compelling need for comprehensive health reform and for providing universal coverage to all Americans. Covering this segment of the population is a necessary aspect if we're going to have true universal coverage.

[The prepared statement of Letitia Chambers follows:]

Testimony of Letitia Chambers
President, Chambers Associates Incorporated
and
Executive Director, Pre-Medicare Health Security Coalition
Before the Labor Management Subcommittee
of the
Committee on Education and Labor
U.S. House of Representatives
February 2, 1994

Mr. Chairman, I appreciate your invitation to testify at this hearing to consider the impact of health reform on workers and retirees. I am appearing today on behalf of a broad-based Coalition of unions, corporations, state and local government organizations, aging groups, and other public interest organizations. A list of those participating in the Coalition is attached.

Health Security for Individuals

This group is concerned with the health care coverage of a particular segment of our society that could easily fall through the cracks in health reform, just as it often does today -- those aged 55-64 who are no longer in the work force or who are unemployed, but who are not yet eligible for Medicare.

Many persons in this 55 through 64 age group, the "Pre-Medicare Population," do not have secure health care coverage. In America today, we have an employer-based health system, which the President proposes to expand. In an employer-based system, it is unfair to discriminate against those who are not working. This is particularly true with vulnerable older persons who are not working, i.e. those who are displaced, unable to work, underemployed, or retired. *To advance the goal of universal coverage, Health Care Reform must assure health coverage for non-working Americans 55-64.*

Workers 55-64 are vulnerable to being laid-off or displaced and losing health benefits. Older workers, with higher average wages and rapidly escalating health costs, who lose their jobs during corporate down-sizing, re-structuring, and defense "conversion," often have great difficulty becoming re-employed. Of those who do find work most receive fewer benefits and replace less than 80 per cent of their former wages.

Workers over age 55 who become unemployed subsequently leave the work force entirely at much higher percentages than younger workers. According to a CBO analysis of data through 1990, over one-half of displaced

workers 60 and older, and over one-fourth of displaced workers between the ages of 55 and 59, left the labor force. Such forced retirements artificially held down the unemployment rates for these age categories, which otherwise would have been much higher. We know that hiring discrimination against older persons is fueled to some degree by their high health care costs. The sad thing is the fact that older displaced workers become retirees not by their own choosing, but because of the lack of labor force mobility for individuals in this age range.

Persons in jobs requiring physical labor--jobs that are filled disproportionately by minority workers--are especially vulnerable to job loss as they age. Because minorities die at younger ages statistically, this population faces a kind of double jeopardy -- crucial years before age 65 with no coverage or inadequate coverage, and then a lower life expectancy which too often means they do not receive the health coverage from Medicare that they earned in their working years. Laid-off workers often have only COBRA health benefits for up to 18 months-- benefits which must be paid entirely by the displaced worker. Yet three-fourths of Pre-Medicare retirees have family incomes of less than $25,000.

Older workers are also highly susceptible to "job-lock." Fear of reduced health care coverage and poor job prospects stop older workers from changing jobs or trying something new. This impairs upward labor mobility for younger workers and may lower overall productivity.

More than one-fourth of the 21.2 million Americans aged 55-64 are not working, and many have inadequate health care coverage. Most of them receive no health benefits from former employers. They are faced with the choice of paying five to ten times more for health insurance than those with employer-paid coverage, often for inferior coverage, or going uninsured, as an estimated 2.7 million people in this age group did in 1992.

The GAO estimates that 96% of America's employers offer no health benefits to former employees. A national survey shows that companies are steadily reducing or eliminating such benefits. For those companies that still offer coverage, generally large employers, the recent change in the Federal Accounting Standards Board (FASB) rule, which requires reporting on financial statements the liability associated with employer coverage of retiree health benefits, has increased the pressure on companies to cut back such benefits, or even terminate them -- particularly for newer workers.

Impact on Competitiveness of U.S. Corporations

U.S. corporations that still provide retiree health benefits are often hurt competitively. Global competitors do not pay directly for retiree health care; domestic competitors may have a younger work force or a much lower ratio of retirees to active workers, or a policy of no retiree health benefits. Progressive companies providing retiree health benefits are increasingly faced with the "Hobson's choice" of reducing such benefits--increasing the problems of Pre-Medicare retirees--or becoming less competitive. Over time, the reduced ability to compete inevitably results in even greater job loss.

The President's health reform plan addresses the problems faced by the "Pre-Medicare population" by including a provision under which the government pays the "employer share" of health coverage for the non-working Pre-Medicare Population in order to protect vulnerable individuals. This is a key provision needed to meet the goal of universal health coverage. It will also increase labor mobility and productivity and improve the competitiveness of U.S. companies.

This provision also is consistent with a general principle of comprehensive health reform that there should be a level playing field between all employers so companies are not forced to compete on the basis of health care costs. Unless this principle is adopted with respect to retiree health insurance coverage, as well as coverage for the active workforce, significant retrenchment and job loss in key manufacturing industries in the U.S. can be expected to continue. Many of the companies with large retiree health liabilities face declining market share in international markets, resulting in lower production and employment. This in turn can create a vicious cycle. As these companies downsize, the ratio of retirees to active workers increases. Ironically, higher productivity in industries that have invested in modernization to increase competitiveness, certainly a desirable development for the U.S. economy, has also had the perverse impact of increasing the ratio of retired to active workers. The FASB liabilities and competitive disadvantage become worse, leading to a further decline in market share, followed by more cutbacks in production and additional job loss. Thus, in addition to assuring the security of health care benefits for the Pre-Medicare population no longer in the workforce, the Pre-Medicare provision in the Clinton health care plan also will play an important role in restoring the competitiveness of many important sectors of the American economy. This not only will preserve existing jobs; it also will provide the basis for renewed economic growth that can generate new jobs in the future.

Budgetary Impact

The budgetary impact of the provision in the President's bill to pay the 80% "employer" share of premiums for non-working individuals aged 55-64 is

estimated by the administration at a cost of $11.6 billion through the year 2000.

This cost is fully offset by the following revenue raisers which total $11.7 billion over the same time period:

(1) For calendar years 1998-2000, employers will pay 50 percent of the greater of (a) the average cost of providing health benefits to this group during the years 1991-1993, indexed for medical price increases, or (2) the money employers will save in the current year by not having to pay for the health benefits for this group. **This employer assessment raises $11.5 billion.**

(2) Retirees in this group with high incomes will have to pay a tax to recapture the subsidy they receive. **This tax provision saves $0.2 billion.**

The net result over the budget period is revenue in excess of costs of $100 million which is used to help pay for other provisions in the President's bill.

A table which specifically outlines the cost and revenues associated with the Pre-Medicare provision is attached.

Conclusion

Mr. Chairman, federal coverage of the "employer" share for the non-working Pre-Medicare population is an important aspect of providing universal coverage. It will assure coverage for an important demographic group which has significant problems related to affordable health care coverage. The beneficiaries of this provision include the individuals who are uninsured or underinsured who will gain coverage, as well as the individuals now covered who will gain the security that they will not lose the coverage they have. The economy as a whole will also benefit through increased labor mobility and productivity and improved competitiveness of U.S. companies.

The Pre-Medicare Health Security Coalition recognizes the compelling need for comprehensive health reform and for providing universal coverage to all Americans. This Coalition stands ready to provide information and to work with the Committee as the Congress and the administration work together to enact comprehensive reform.

BUDGETARY EFFECTS OF PRE-MEDICARE PROVISION UNDER CLINTON HEALTH CARE REFORM PROPOSAL
Administration estimates (billions of dollars)

Fiscal Years	1994	1995	1996	1997	1998	1999	2000	Totals 1994 2000
PRE-MEDICARE PAYMENTS FOR RETIREES AGES 55-64 *	**0.0**	**0.0**	**0.0**	**0.0**	**3.0**	**4.2**	**4.4**	**11.6**
OFFSETS	**0.0**	**0.0**	**0.0**	**0.0**	**-2.4**	**-4.5**	**-4.8**	**-11.7**
Assessment on Employers for Pre-Medicare Peyments *	0.0	0.0	0.0	0.0	-2.4	-4.4	-4.7	-11.5
Recapture Pre-Medicare Peymants From High-Income Recipients *	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.2
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.6**	**-0.3**	**-0.4**	**-0.1**

NOTE. TOTALS CALCULATED FROM ADMINISTRATION ROUNDED NUMBERS

EXPLANATION OF PROVISIONS

Pre-Medicare Peymente for Retirees Ages 55-64
The Federal govarnment will pay 80 percent of the premium cost for retirees ege 55 through 64 who ere not working in second careers end who ere vested for Social Security (40 quarters of covarage).

Assessment on Employers for Pre-Medicare Peymente
For calender years 1998-2000, employers would have to pay 50 percant of the greeter of:
(1) the average cost of providing health benefits to retirees between the egas of 55 end 64 during the years 1991-1993 indexed for medical price increases, or
(2) the employer savings in the current year for providing health coverage to retirees between the eges of 55 end 64
Reporting requirements and interest and penalties for failura to maka timely payment would epply in tha sema manner as in the case of Federal employment taxes
The Federal govarnment does not transfer an amount equal to this tex for its retirees. On the other hend, the Federal government assumes responsibility for paying the 80 percent premium for all individuals affactad by this retirement provision. The offset from this provision is within $0.1 billion of the cost for the years 1994-2000 baceusa employers pay the assessment whether or not their retirees take second career jobs.

Recapture Subsidies From High-Income Recipients
Effectiva January 1, 1998, individuals with modified Adjusted Gross Incomes of $90,000 for an individual and $115,000 for e couple would repay the retirea subsidias. The subisidy would be recaptured over the texeble income range of $15,000 abova the modified AGI for individuals end $30,000 for couplas.

Notes
* *Source: Administration Handout dated 2 Nov. 93 that accompanied testimony of Judith Feder, Ph.D, and Kenneth Thorpe, Ph.D., of HHS.*

Prepared by CHAMBERS ASSOCIATES INCORPORATED

PRE-MEDICARE HEALTH SECURITY COALITION

The Pre-Medicare Health Security Coalition was formed to assure health care security for middle-class Americans 55-64 and their families. The broad-based coalition of organizations represents persons who are displaced, dislocated, unable to work, under-employed or retired. The coalition includes labor, business, senior citizens, consumer, education, and state and local government organizations.

The following is a partial list of organizations which have been participating in the Coalition:

AFL-CIO
Air Line Pilots Association
ALCOA
Allied Signal
American Airlines
American Association of Retired Persons
American Federation of State, County and Municipal Employees
American Iron and Steel Institute
Armco, Inc.
Bethlehem Steel Corporation
Bituminous Coal Operators Association
Chrysler Corporation
Citizen Action
Communications Workers of America
Ford Motor Company
General Motors Corporation
International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America
International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers
LTV
National Council of Senior Citizens
National Council on Teacher Retirement
National Education Association
National School Boards Association
National Steel
NYNEX
Owens-Illinois
International Union, United Automobile, Aerospace & Agricultural Implement Workers of America (UAW)
United Mine Workers of America
United Steelworkers of America
USX

Chairman WILLIAMS. Thank you. Let me ask a question and ask each of you, beginning with Ms. Kolker, to respond briefly to it. Then I want to follow it up.

I know each of you know this, but for the purpose of the hearing record, let me define what I'm asking about. I'm going to ask you if you support universal access or universal coverage, universal access meaning that every American has access to coverage; universal coverage means that we develop a system which provides each American with coverage.

Ms. Kolker, universal coverage or universal access?

Ms. KOLKER. We support universal coverage, but we have an additional sort of thought about universal access, which is, access to us means affordability, so that you can have universal coverage, where everybody is in fact covered, but if the premiums are so high or if the deductibles are so high, then you don't really have access. So in our view, the two sort of go hand in hand.

Chairman WILLIAMS. Thank you. Mr. Wingate.

Mr. WINGATE. We would support that in any circumstance, the poor and the near poor must be subsidized. No question of that. And the issue is, can we afford the kind of program that is being proposed by the President?

We believe it's understated in cost, we believe it would lead to deficit spending, we believe that it unfairly burdens ourselves initially.

Chairman WILLIAMS. Well, the President's plan may not be the right plan here, but I'm not asking that. I'm just asking if you are for some plan or other that creates universal access, or would you prefer a plan that requires universal coverage?

Mr. WINGATE. I wish everybody had ice-cream cones, too. I'd like to see everybody covered, but it's an affordability issue. We have other obligations—building stores, paying taxes.

Chairman WILLIAMS. So given the cost, you prefer universal access as a political and a cost reality?

Mr. WINGATE. If costs were affordable, if the system were truly going to be cost-containing and therefore pay back in the long run, we would like to see everybody covered, absolutely.

Chairman WILLIAMS. All right. Mr. Feltman.

Mr. FELTMAN. We support universal coverage. Now, if we are going to have an employer-based system, which apparently we are—that's seemingly the way we will go, I am told, then employers can handle best, obviously, their employees and their retirees. There is then a proper role for government, and the financing needs to be worked out, but that issue can be isolated as we work to bring universal coverage to all Americans.

Chairman WILLIAMS. And Ms. Chambers?

Ms. CHAMBERS. Yes. The corporate members, and there are many large corporations in the coalition, as well as State and local government organizations, unions involved, all have agreed that they favor universal coverage for all employees as a part of health reform.

Chairman WILLIAMS. Mr. Feltman, given your support for universal coverage, but with a mechanism different than the President would have, would you consider, under your way of providing that

universal coverage, having the employers continue to offer cafeteria plans?

Mr. FELTMAN. Yes, obviously, we would.

Chairman WILLIAMS. So you would let some people opt out of getting health care if they wished and take the cash instead for some other purpose?

Mr. FELTMAN. I don't know that people will do that, because normally an employer who provides a cafeteria plan which has an opt-out or an opt-down will have perhaps three levels, and you can opt for the catastrophic level, but you cannot opt out. Or other employers will say, if you provide evidence of insurability elsewhere, that you have insurance through your spouse, then you may opt out and use that money for dependent care or something else.

Chairman WILLIAMS. There does seem to be some evidence that cafeteria plans would continue cost shifting. Almost everybody in America, until recently I've discovered, has worn this button, which said, "There's no such thing as a free lunch." We learned that in the 1960s and the 1970s; now we all wear the button.

I'm hearing from a lot of business folks around the country, in both letters and testimony—these are people that have probably worn that button for a long time, but are now saying, well, I think everybody ought to have health care, but I don't want to pay for it.

They ought to take the button off. That's asking for continued free lunch for their company. Somebody is paying for their employees' health care in this country. It's called cost shifting. It's knocking us in the head. It's also called a free lunch.

If we're going to get out from under the free lunch concept in America—it does seem to me the President and all of you who recognize the value in universal coverage are onto something: it's the only way to stop free health care lunch.

Mrs. Roukema.

Mrs. ROUKEMA. Mr. Chairman, those are very good questions. I don't know what the answers are, but they are very good questions. That's it, these hearings have developed all the questions. I don't know that it's brought us any closer to the answers.

Let me ask some of these questions in another way. I've noted that—and you can do this any particular order—I noted that each of you in one way or another alluded to the need for insurance reform. Let me ask you the question without coming up with the answer as to how we do that reform.

Can we not initiate this program with the first step being an incremental one for insurance reform? That is, a reform system that will solve the part-timing problem, which is a great problem, particularly for women, but for all kinds of people, employees. It will give us the portability as well as ending the denial of the cherry picking, and that is the denial of insurance for preexisting conditions. When a small-group employer gets one family that has a serious illness, his insurance goes up through the roof.

Now, can't that be step one, or is it impossible to do—alone? I mean alone, without alliances, because I think the alliances and the national board is the sticking point—I think.

Ms. KOLKER. Are you suggesting that we go to a system of universal coverage where everybody is ensured coverage, where there are subsidies that are based on the ability to pay?

Mrs. ROUKEMA. Well, you probably would end up with subsidies because the lower income worker would not be able to afford the premium, yes.

Ms. KOLKER. And that you would had a guaranteed comprehensive benefit package——

Mrs. ROUKEMA. Oh, I don't know about that. Now we're getting into the more complicated subtexts of this. I am not prescribing a comprehensive benefit package, not under this question that I have asked you.

Ms. KOLKER. I think we would feel that that in fact falls short. And I guess one of the issues that comes up in connection with the alliances is how you enable small business and other uninsured individuals to get the same rates that the larger corporations and those with much more bargaining power can afford.

So it seems to me that we have to answer that question of how do you make insurance not just affordable for the individual in terms of subsidies, but how do you make it affordable for small businesses and others who feel that they cannot pay the steep rates that larger employers are paying. And the alliance provides that purchasing ability, of pooling resources, and to spread the risk across many populations.

Mrs. ROUKEMA. Let me ask our business people if they see a way of providing that coverage, absent regulated alliances.

Mr. WINGATE. I think that, you know, it's like being asked, what would you like for dinner, potatoes and what else? We're going to have a lot of things on our plate, and I think to try to limit to one piece at a time is really impossible.

Mrs. ROUKEMA. Is it?

Mr. WINGATE. I believe it is. I think that, you know, the Congress has dealt and the President——

Mrs. ROUKEMA. Well, then how are we going to deal with the problem that you raised? Even though you have a relatively generous—and I don't know how generous it is—a relatively generous policy for your employees, you are opposed to any mandate. How are you going to cover those people?

Mr. WINGATE. You know, if each of us could write our own plan and cause it to be enforced, I think we would all want to deal with quality, access, and cost. And I think those many bullet points that I outlined in our presentation——

Mrs. ROUKEMA. No, but if we don't mandate an insurance reform that requires pools or mandates the employer contribution—I mean, those are the only two alternatives.

Mr. WINGATE. There's the alternative of phasing into it over periods of time; there's the alternative of paying for part of that cost by doing away with some of these concessions I talked about.

Mrs. ROUKEMA. Which concessions?

Mr. WINGATE. The non-taxing of excess benefits.

Mrs. ROUKEMA. Well, there I totally disagree with you. And I asked you to come, and I hate to totally disagree with you here.

Mr. WINGATE. And I think we do have different points of view.

Mrs. ROUKEMA. But wait a minute. I'm just going to put it in very simple terms, Mr. Employer. My constituents did not have in mind that under health care reform, that they were going to be asked to pay more and get less coverage. That's not what 80 percent of the American people had in mind.

Mr. WINGATE. I didn't like it when the tax law was changed on partnerships, either.

Mrs. ROUKEMA. Yes, but listen, to call it health care reform and turn around and because of some arbitrary, purist idea that market forces are better in place if you don't have any tax advantages, we call taxing health insurance health reform—that's not in my book.

Mr. WINGATE. If it encourages unnecessary and unuseful procedures, I think that is——

Mrs. ROUKEMA. What unnecessary and unuseful procedures? The one that I used as an example of sending a woman after 24 hours?

Mr. WINGATE. No, I don't think that's at all unnecessary.

Mrs. ROUKEMA. Pardon me?

Mr. WINGATE. I don't think that's unnecessary at all.

Mrs. ROUKEMA. Yes, but see, then we get into a real question. You know, if it's not my mother, not my husband, not my child, then what's necessary and what's unnecessary? That's where you get into big problems.

Mr. WINGATE. But if plans go well beyond that which is even defined by Clinton as acceptable coverage, therefore physicians, hospitals overprovide. The New England Journal of Medicine and the Rand Corporation both have testified that 30 percent of health care delivered in the United States today is unnecessary and unhelpful.

So one of the ways you get there is to oversupply plans. I'm not saying we should take away something that's valuable and necessary, but we should certainly not encourage that which is costly and unnecessary.

Mrs. ROUKEMA. Well, then we get into malpractice and defensive medicine.

Mr. FELTMAN. Congresswoman?

Mrs. ROUKEMA. Yes, Mr. Feltman.

Mr. FELTMAN. If I may just talk a little bit about just some discussions we have had with our members who are in the insurance business. We have sat them down. They are from the very largest to the very small regional firms. And a couple of things have become clear.

Number one, they would be willing, if all of them did it, to issue insurance without underwriting, but it is now a competitive disadvantage and they dare not talk about it.

Mrs. ROUKEMA. That's true.

Mr. FELTMAN. And so I will talk about it. Secondly, claims forms. They sat and they said, you know, we don't learn anything on that claims form that we don't learn from the bill from the provider. And if there's something on the bill we have to question, it's never on the claims form; we have to call the provider. So why don't we avoid all that paperwork. And they began, then, talking about other things.

And we were then beginning to do what I call isolating the germ or the virus, because in health care reform, it's almost as if we are saying there is a problem, and we can say it's a crisis or we can

define crisis differently, all of us, but are we running out looking for the universal solution, that universal immunization?

If you're a medical researcher and you're working, for example, on AIDS, first you try to isolate that germ or that virus, and then you work on the cure or the prevention. You're suggesting that perhaps the first step is insurance reform. The longest journey must begin with that single first step.

Mrs. ROUKEMA. Ms. Chambers.

Ms. CHAMBERS. As I understand what you're referring to as insurance reform, it would include the pooling to achieve community rating.

Mrs. ROUKEMA. Now, if you had asked me that a year or a year and a half ago, I would have been resistive to it, but I think that is the inevitable.

Ms. CHAMBERS. Well, I think the alliances are the mechanism through which the President's bill would pool to achieve community rating. And some form of alliance-type mechanism, whether it's called a purchasing cooperative or an alliance or just a pool, and that has some administrative structures and regulations, is going to be necessary to achieve that end.

So I really think—you referred to it earlier as a semantic difference—if you're setting up that kind of a mechanism, then it can be more or less regulatory, but that's what I think I would call health reform. And health reform clearly includes insurance reform, and it goes beyond that, because it includes subsidies, it includes making sure that everyone gets covered.

Mrs. ROUKEMA. Nothing here is easy or simple. Mr. Wingate, do you want to have the final word?

Mr. WINGATE. I just wanted to comment that the self-insurance under which we operate now encourages us to do things that we wouldn't do if we didn't have that obligation.

Mrs. ROUKEMA. Is that right?

Mr. WINGATE. It encourages us to give rest breaks, to have workout periods for our distribution employees, it encourages us to publish recommended procedures when you become ill to avoid cost in the first place. So I think one of the incentives that would be removed if we were to move completely to a single payer or a system of a single buyer in each area would be the incentive that companies now have to maintain a healthy workforce.

Mrs. ROUKEMA. I think the self-insured plans, in my experience, are probably the best that we have. Thank you very much.

Chairman WILLIAMS. Well, we want to again thank members of this panel. We're not unmindful, as you can tell by both the interest today and the questions, we're not unmindful of the difficulties that face us in trying to resolve the current health care dilemma, however we're going to state the problem—crisis, dilemma, health care, health insurance, whatever.

And each of you have been very helpful, including your three counterparts that appeared on the first panel. I would encourage you to stay in touch with the committee and your organizations to continue to stay in touch with the committee.

Just the fact that you have come here now and we have heard from you doesn't mean we want you to go away. We invited you to come here because we think that you represent critical and impor-

tant thinking on this enormous task that we are undertaking, so please continue to stay in touch with myself, the staff, and the other members of the committee.

Thank you all very much. The hearing is adjourned.

[Whereupon, at 12:55 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

H.R. 3600—"THE HEALTH SECURITY ACT: IMPACT ON PROVIDERS"

THURSDAY, FEBRUARY 10, 1994

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:15 a.m., Room 2175, Rayburn House Office Building, Hon. Pat Williams, Chairman, presiding.

Members present: Representatives Williams, Clay, Miller, Owens, Payne, Unsoeld, Engel, Green, Woolsey, Romero-Barcelo, Roukema, Gunderson, Boehner, Hoekstra, and McKeon.

Also present: Representatives Reed and Strickland.

Staff present: Phyllis Borzi, Susannah Ringel, Anthony Giles, Karen Vagley, Apurva Desai, Jon Weintraub, Russ Mueller, and Ed Gilroy.

Chairman WILLIAMS. Good morning. I call to order this hearing of the Labor-Management Subcommittee, where we continue what has been a long series, thus far, of hearings on national health care reform. Today, we focus again on issues of concern to health care providers.

This committee has had a very aggressive hearing schedule, not only here in Washington, but across the country. We have, of the three subcommittees which have primary jurisdiction over health care reform, had the most aggressive schedule of hearings across the United States.

As the members of this subcommittee and I have been out on hearings and on site visits, we have had the opportunity to hear the concerns of many doctors, nurses, hospital administrators, board members, and others who are involved in the delivery of medical services.

We want you to know that our members have visited literally hundreds of hospitals and clinics. We visited migrant health centers, dozens and dozens of community health centers, and we have done it in both the inner cities as well as the most rural areas in the United States. We have gone to public hospitals, private hospitals, teaching hospitals.

In every facility, we have taken time and, pleasantly, the providers have also taken time to give us the opportunity to visit with them and see what's on their minds, get their recommendations. One cannot spend the time we have spent in America's clinics, hospitals, and centers without being extraordinarily impressed with

the thoughtfulness, the dedication, and the very long hours that America's health care providers are giving to America's sick.

They tell us there is a crisis. We don't run into health care providers who tell us there is no crisis. They may define the "crisis" differently, but they all use the word. They have said they want us to be bold about reform. They define "bold" differently, but they all want action, they want it in this Congress, and they want it, under their terms, to be bold.

I think it is clear that, by far, most of the people that we have asked this question of, do you want universal access or universal coverage, most of them have said universal coverage. Doctors are more evenly split than are other providers about the answer to that question, but most of the providers have come down on the side of universal coverage. We have asked them individually as well as collectively at our hearings.

They all want administrative simplicity; there's no question about that. They want to be freed from the forms so they can go back to the bedside. And if we don't do anything else in this Congress, we ought to achieve that.

Today, the subcommittee will hear from a broad section of health professionals who are arrayed before us, hear from you about the various approaches to reform that you would counsel us toward. There are changes, of course, today, as there always have been, going on on the health care front. We want to hear about those today.

So we welcome all of you. You are very kind to take time out and come here to be with us.

An important and integral component of this committee—and I'm almost embarrassed to even say this, but I just want to get it said—is, the ranking member, Mrs. Roukema, and our colleagues on the Republican side. As everyone knows, this is going to be a compromise. Hopefully, it is not going to be such a compromise that we have watered it down to the point where it doesn't have effect.

But we are all going to work together. We want you to understand that. The President knows it. When we are finished, we hope to come out with a proposal which, although we may not all agree on every part of it, will be an improvement over what anybody in the Congress has introduced, we hope.

Mrs. Roukema.

Mrs. ROUKEMA. Thank you, Mr. Chairman. I am pleased to hear your references to compromise, and we shall explore that further as we go along.

To concentrate on our hearing here today, as you well know, I have an intense interest in this morning's hearing and certainly our panel of witnesses as representative of the provider community.

First, I want to ask your indulgence, Mr. Chairman, and the indulgence of my colleagues, because you have heard what I am about to say again, but I want our panelists to hear it. I come with a background of a deep and long interest in health care. In fact, some have said that I have been practicing medicine without a license for years, and that is probably true.

My disclaimer here this morning is the fact that my husband is a physician. He is a practicing psychiatrist in New Jersey, and he

also teaches at a medical school, teaches psychiatric residencies at a medical center. As I am wont to tell my constituents frequently, and I like to remind them, my husband is not one of those rich doctors; he's a poor doctor.

Of course, they then usually laugh, and I have to correct myself and say, he's not a poor doctor, he's a very good doctor, but he's at the low end of the income scale. And then they laugh even more, because they don't believe any doctors are at the low end of the income scale.

I then go on to say that, if the problem were only all the rich doctors and the greedy, expensive hospitals, we would be able to solve the problem with relative ease. But our problem is far more complicated than that. In fact, I think Senator Chafee and I agreed the other day, on a panel on which we appeared, the only experts in this field are the people who realize how little they know. Because the more you know about the complex issues of health care, the more complicated it becomes.

So I welcome those of you here today, now knowing of my special interest, and want to express some of my concerns, and hope that you are able to address them in your testimony.

First is, of course, the question of the managed care and the cost controls that they are to bring. One issue that must be discussed here today—and, as you know, President Clinton's plan puts great emphasis on HMOs and PPOs as managed care health care alternatives that are supposed to save huge costs. Simply put, managed care may, in many cases, limit access to care by simply turning down or refusing to either refer to specialists, or to say no to tests that they feel are too expensive, or treatment modalities.

Examples are countless, I believe, of care denied or delayed, or treatments approved only after doctors haggle for hours with insurance clerks. Unfortunately, these decisions as to appropriate care and quality of care are no longer in the hands of doctors and patients but too often in the hands of insurance companies and faceless bureaucrats.

This, I would submit, is not the quality of care that Americans have heretofore believed was their birthright in this country. Moreover, I would guarantee that skepticism among the public will quickly become anger and outright rejection, when the first mother, for example, is released from a hospital maternity unit after 24 hours and has a serious, life-threatening hemorrhage at home.

I think those quality of care questions have not been part of the debate so far. In other words, it is easy enough to say we are going to save money by releasing people early from the hospitals, but you must also consider the care of the patient and the quality of the doctor's recommendations.

Quality of care is also part of the cutting edge of medical access. The most advanced technology in the world is here in the United States. I'm afraid the people, not only the President, but people on the other side of my side of the aisle who speak rather glibly about cutting back health care inflation, have failed to consider or understand that an enormous part of that health care inflation is the high-technology medicine and the advanced methodologies that we have today that continue to make our system the best health care system in the world.

I will not go into, in the opening remarks, the lack of credibility in the cost estimates and the savings, the questions of whether or not the Medicare cuts are really draconian. I believe they are. I would like to hear what this panel has to say. I will save the rest of my observations for the question period.

I do want to tell our panel here today, the providers, that we are deeply in debt to all the good work you do in providing health care to our Nation. It's an American birthright.

Thank you very much.

Chairman WILLIAMS. As the members of the committee can see, we have a good, healthy number of witnesses. We will, of course, take opening statements, but we would really prefer that, if there are opening statements, they be very brief, so that we can get on with hearing from our witnesses.

Any members on my left wish to?

[No response.]

Chairman WILLIAMS. Any other members on my right?

[No response.]

Chairman WILLIAMS. Well, you are all very kind. Thank you all.

Any statements to be submitted for the record?

Mr. GREEN. Mr. Chairman, I have a statement for the record.

Chairman WILLIAMS. Mr. Green has a statement for the record. Without objection, that opening statement will be placed in the record.

Gene, we appreciate your kindness in doing this.

Without objection, Mrs. Unsoeld's opening statement will be placed in the record.

Our first witness is representing the Montana Hospital Association and the American Hospital Association, Mr. John Flink of Helena, a city I know well, out in Montana.

Mr. Flink, it's nice to see you here.

I want to say publicly, and I do this as carefully and cautiously as I can, because we have great organizations represented here today, but because I said it to your group privately, I want to say it publicly, speaking just for myself, there has been no group as helpful to this subcommittee in delivering facts in a timely manner, in giving us their counsel and recommendations, as has the American Hospital Association.

I am indebted to them, although I may not do what they want.

But I do want to say thank you publicly. Your organization here, as well as in Montana, of course, has been extraordinarily helpful, and we really are very grateful to you. Thank you.

Please proceed.

STATEMENT OF JOHN FLINK, VICE PRESIDENT, MONTANA HOSPITAL ASSOCIATION, HELENA, MONTANA, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. FLINK. Thank you, Mr. Chairman.

My name is John Flink, vice president of the Montana Hospital Association. I am here today on behalf of the American Hospital Association, which represents more than 5,000 hospitals.

Obviously, at this time, the impact of health care reform on hospitals is perhaps impossible to determine, but I can say, without hesitation, that our greatest fear is the impact of no reform at all.

Without reform, Medicare and Medicaid will remain the fastest growing parts of Federal and State budgets, one in four Americans will lose their health insurance in the next two years, those with health insurance will still have no guarantee that they will keep their coverage when they change or lose their jobs, as much as 40 cents of every dollar small business spends on health insurance will still be consumed by administrative costs, and paperwork will remain a costly nightmare for doctors, hospitals, and patients.

America's hospitals deal with these issues 24 hours a day, every day of the year. We know the issues are complicated. Our vision for health care reform is based on three principles: guaranteed, affordable coverage for every American, delivery system reform, and fair financing.

To achieve these goals, AHA has targeted six initiatives: First, access and coverage for all. Quite simply, without universal coverage, reform does not work. Without universal coverage, hospitals will continue to face problems such as uncompensated care, cost-shifting, a focus on acute rather than preventive care.

The employer mandate is the most practical road to universal coverage, because it builds on the strength of current employer-employee and insurer relationships, and because employers already provide health coverage for nearly 90 percent of the nonelderly, privately-insured population. We also recognize that, to achieve universal coverage with an employer mandate, assistance will have to be provided to those small businesses and low-income individuals who cannot afford to pay their full share of the cost of insurance.

The second initiative is, defining accountable health plans as community-based, locally rooted, and publicly accountable community care networks. These local networks are the cornerstone of AHA's reform effort.

As you know, Mr. Chairman, there are plenty of examples in Montana. Hospitals in Kalispell and Billings are forming their own community health plans, where they would not only provide health care but also share in the financial risk of providing that care. In December you witnessed firsthand how our telemedicine network is helping provide health care to Montanans in areas that might otherwise not have access to health services.

The third initiative is integration of Medicare into these networks. Medicare accounts for about 40 percent of hospital revenues nationally and 41 percent in Montana. Keeping Medicare beneficiaries in traditional fee-for-service plans undermines any movement toward reform. Hospitals that treat a disproportionate share of Medicare patients, such as small rural hospitals, will be particularly hard-hit by this double standard. I have included in my written testimony a number of incentives that could be used to move Medicare patients toward integrated care networks.

The fourth initiative is limiting the role of alliances to organizing the purchase of coverage for small businesses and individuals. AHA envisions a reformed health care system in which many employers and individuals contract directly with community care networks to provide health services. We also favor the creation of insurance pools to make coverage more affordable for small businesses and the self-employed.

Our concern with alliances is that, in addition to a broker or clearinghouse role, they are being assigned too many regulatory functions. These add up to a lot of responsibility for a brand new, untested entity.

The fifth initiative is opposition to Medicare and Medicaid budget reductions. Medicare should not be treated as a financial cookie jar to fund health care reform. Hospitals are already underpaid for treating Medicare patients, and rather than weakening Medicare further, we suggest other alternatives to help finance reform. A list of those alternatives is also included in my written testimony.

Sixth, replacing top-down, formula-driven, global budget caps with targets. AHA strongly opposes global budget approaches that are arbitrary and have no relationship to patient needs. There must be a direct link between promised health benefits and the cost of providing those benefits, as well as flexibility to respond to changing health care spending needs, demographic changes, new technology, and other factors. Global budget targets would be a more appropriate way to measure health spending.

In closing, Mr. Chairman, I end where I began. AHA has laid out its principles for health care reform, and these will be the ruler against which we will measure any reform proposal. These proposals came about because America's hospitals have been diligent and determined in their wish to play a positive role in the health care reform debate.

We aren't simply shooting down other people's proposals where they disagree with our goals. Instead, we are offering constructive solutions that we believe can help bring about true reform. We have based those solutions on our experience on the front lines of health care delivery, and we bring them to this subcommittee with every hope that they will be helpful, as you and your colleagues take your place on the front lines of health care reform.

Thank you very much.

[The prepared statement of John Flink follows:]

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Statement
of the
American Hospital Association
before the
Labor-Management Relations Subcommittee
of the
House Education and Labor Committee
on
Health Care Reform

February 10, 1994

Mr. Chairman, my name is John Flink, vice president of the Montana Hospital Association. I am here today representing the American Hospital Association and its 5,000 institutional members. It is a pleasure to be here in the cause of moving health reform forward, and I am especially pleased, Chairman Williams, to be testifying before a fellow Montanan.

The President and First Lady have done an admirable job putting this issue at the top of the American agenda. And, now, Mr. Chairman, Congress begins the nuts and bolts job of crafting specific legislation. It's easy to see that there are many players, many plans, and many possibilities to be considered.

Obviously, the impact of health care reform on hospitals is almost impossible to determine until all those possibilities are carved into a final result. But, I can say with no hesitation that our greatest fear is the impact of no reform.

Without reform, Medicare and Medicaid will remain the fastest-growing part of our federal and state budgets.

Without reform, one in four Americans -- that's 63 million people -- will lose their health insurance in the next two years.

Without reform, those with health insurance still have no guarantee that they will keep their coverage when they change jobs, or lose their jobs.

Without reform, as much as 40 cents of every dollar small business spends on health insurance will still be consumed by administrative costs.

Without reform, paperwork will remain a costly nightmare for doctors, hospitals and patients.

Mr. Chairman, America's hospitals deal with these issues 24 hours a day, every day of the year. We know the issues are complicated. Because of this, our vision of a better system was two years in the making. Complex as those issues are, our vision is based on three simple principles: guaranteed affordable coverage for every American; delivery system reform; and fair financing.

We will adhere to our goals as the reform debates moves from rhetoric to resolution. To achieve these goals, AHA has targeted six initiatives, each of which I will describe briefly:

- **Access and coverage for all**, financed in a broad-based manner, including an employer mandate

Guaranteed universal access and coverage is one of AHA's critical priorities in health care reform. We believe it should be achieved within a reasonable period of time through a pluralistic financing system, with an employer mandate at its base. Quite simply, without universal coverage, reform does not work. Without universal coverage, we'll continue to face problems such as uncompensated care, cost-shifting, and a focus on acute rather than preventive care.

The employer mandate is the most effective and practical road to universal coverage. It builds on the strength of current employer, employee, and insurer relations, and preserves these local ties. It is the strongest building block for universal access because employers already provide health coverage for nearly 90 percent of the nonelderly, privately insured population.

Universal coverage through an employer mandate means a shared responsibility between the employer and the employee in financing insurance. Some employers and low-income employees will be unable to afford their full share of the cost. Therefore, universal coverage will still require subsidies for those employers and employees.

AHA is concerned that, without an employer mandate, subsidies to individuals would be greater because of a lack of employer participation in sharing the costs. Since employer-based coverage has worked well for millions of Americans, we think it's the surest route to universal coverage.

- **Defining accountable health plans as community care networks℠**, which are community-based, locally rooted, and publicly accountable

Local health care providers, social service agencies, community organizations, and others who integrate their services to bring seamless care to patients are the cornerstone of AHA's reform effort. We believe that restructuring health care delivery at the community level is essential if we are to refocus our energies on improving health status in our communities and also on improving the affordability of health care.

Hospitals throughout the State of Montana are exploring ways to work together through collaboration and integration to better provide health care to the communities they serve. Hospitals in Kalispell and Billings are attempting to form their own community health plans, where they would not only provide health care, but also share in the risk of providing health care.

As you know, Mr. Chairman, we in Montana are proud of the innovative ways we have developed to provide health care to our citizens. In December, you witnessed first-hand how our telemedicine network is helping provide health care to Montanans in areas of the state that might otherwise not have access to health services. In addition, the Medical Assistance Facilities now operating in five of our state's communities could serve as a model for providing care in communities that cannot sustain a traditional hospital.

All three of the reform proposals in the political "center" -- the Administration's, Senator Chafee's, and Congressman Cooper's -- could accommodate our approach to the formation of integrated health care delivery systems. In addition, all three bills contain incentives to move toward integrated care by virtue of their insurance reform provisions.

However, any final reform proposal must contain more federal guidance for qualification as a health plan. Specifically, health plan criteria should ensure that enrollees receive coordinated care, putting an end to the fragmentation so prevalent today. They also should ensure that plans are held accountable to the enrollees they serve by providing regular reports on their performance in that community with respect to quality outcomes, cost, and member satisfaction, including the development and implementation of plans on how to improve the health status of their enrollees.

It is equally important to remove the barriers for providers to work together, eliminating expensive duplication of services and technology, and for establishing a seamless system of care that works better for patients, and then to encourage the use of capitated payment to these provider networks -- setting a fixed, up-front fee for each person enrolled -- to encourage economic self-discipline and community self-determination in the use of available resources. In that regard, it is vital that antitrust policy allow hospitals and their communities the flexibility to assess local health care needs and implement the strategies necessary to address those needs.

- **Integration of Medicare into these networks by providing increased opportunities and incentives**

To achieve the maximum in savings and efficiency, it is essential that the growing Medicare population be part of the same reformed system as other Americans. Our current health care delivery system is a tangled web of conflicting incentives for both patients and providers.

Providers in a reformed system who form collaborative groups, provide integrated care, and are paid a fixed fee for each enrolled patient have more incentives to provide cost-effective care, including an important emphasis on preventive services and health promotion, than those in traditional fee-for-service systems. And patients in a reformed system will be able to make informed choices among plans, based on reports to the public on quality and cost-effectiveness.

Keeping Medicare beneficiaries, who account for about 40 percent of hospital revenues nationally and 41 percent in Montana alone, in traditional fee-for-service plans undermines any movement toward reform. Hospitals that treat a disproportionate share of Medicare patients would be especially affected. Given Medicare's historical underpayment record, exacerbated by proposed reductions in some reform plans, these facilities will be disadvantaged in their efforts to become part of integrated care networks because they will be financially unattractive to potential network partners.

Our goal is to move Medicare patients into integrated delivery systems, and we have identified a number of options that could increase enrollment in existing Medicare managed care arrangements. These options include: making managed care arrangements less expensive for beneficiaries than a fee-for-service option by:

- waiving a current cost paid by Medicare beneficiaries -- for example, deductibles, copayments, or a limit on inpatient days;
- offering benefits in a managed care arrangement that are currently excluded from Medicare coverage -- such as prescription drugs, long-term care, or more preventive services; and
- offering a point-of-service option in Medicare managed care arrangements, which would allow a patient to "opt-out" of the capitated payment arrangement at any time to see a provider of his or her choice -- but at a higher cost to the beneficiary.

This would open to Medicare beneficiaries the same care and payment options currently available to other Americans.

Any of these options would need to be linked to a vigorous effort to educate older Americans about the advantages of these plans and the satisfaction of those who already use them.

- **Limiting the role of alliances** to organizing the purchase of coverage for small businesses and individuals

AHA envisions a reformed health care system in which many employers and individuals contract directly with community care networks for the provision of health services. We favor the creation of insurance pools to make coverage more affordable for small businesses and the self-employed.

Such a role was originally envisioned for what were once called health insurance purchasing coops -- acting as a health care "broker" for individuals and small businesses. Our concern with the alliances that purchasing coops have evolved into is that they are being assigned too many regulatory functions in addition to the "broker," or "clearinghouse" role.

For example, the Administration proposal calls for alliances to negotiate health plan premium bids, negotiate a maximum fee schedule for fee-for-service care, ensure the availability of health plans in underserved areas, enforce global budgets and, at the state level, set provider rates and limit plan enrollment.

These roles add up to a lot of responsibility for a brand new, untested entity. Some alliance activities -- conducting an annual enrollment, collecting and disbursing funds, and risk-adjusting payments to health plans according to federal guidelines -- are, for the most part, necessary functions in any reformed health system.

Our recommendation is that the scope of health alliances should be limited to four basic functions: serving as a risk pool for small businesses and individuals; offering an open enrollment period with the opportunity to join any of the qualified health plans; disseminating easily comparable data on quality, cost, and enrollee satisfaction to the public about each plan; and collecting community-rated individual and small business-premiums and distributing risk-adjusted premium amounts to the health plans.

- **Opposition to Medicare and Medicaid budget reductions** in provider payments and identifying alternative sources for financing reform

We agree that growth in health care spending must be moderated. The way to achieve this is to fundamentally restructure our health care system through establishing the community care networks I've talked about. But significant reductions in Medicare spending undermine our ability to transform the health care delivery system and threaten our ability to continue to deliver quality patient care -- not just to Medicare patients, but to all patients.

Too many reform plan authors are treating Medicare as a financial cookie jar, into which they dip their fiscal fingers in hopes of funding their proposals. The president's plan, for instance, calls for $118 billion in Medicare reductions by the year 2000. And these reductions are not isolated; they come on top of Medicare reductions already sustained in OBRA 1993. Of the $56 billion in five-year reductions contained in OBRA 1993, $24 billion will come from hospital care for the elderly. These reductions are added to the $43 billion in Medicare cuts approved as part of the 1990 budget agreement.

We certainly support the added benefits -- long-term care and prescription drugs -- that proposed Medicare cuts in the Administration's bill would help fund. But we cannot support further underpaying hospitals to pay for these benefits.

Such unprecedented reductions would be unwise policy at any time, but are especially dangerous as we attempt to reform our health care delivery system. Providing universal coverage is not cost-free. Expanding the covered population, restructuring the health care delivery system, reconfiguring hospitals and other services for the future, and investing in new technologies to meed the demands of the new system -- all will require adequate resources.

Infrastructure investments we all endorse -- such as new information systems and computerized patient records -- will require an up-front investment. Without that investment, the benefits of improved efficiencies will never materialize.

In 1991, according to the Prospective Payment Assessment Commission (ProPAC), Medicare payments fell 12 percent short of meeting hospitals' costs for those patients. That is why two-thirds of America's hospitals must subsidize the cost of treating Medicare patients. In 1992, Medicare payments to Montana hospitals fell short of hospital charges by $157.3 million, and Medicaid payments were $32.8 million less than hospital charges.

It is true that some improvements in efficiency can be gained in hospital and physician settings. But, according to ProPAC, 60 percent of hospital cost increases from 1985 to 1989 were due to factors beyond the control of hospitals, including inflation in the general economy and the increasing intensity and complexity of patients' health needs.

Rather than weakening Medicare further by cutting its finances, the following list of alternative financing options is offered:

- Use the estimated $58 billion in savings and taxes now targeted for deficit reduction to help finance the health care reform effort;
- increase taxes on alcohol, tobacco and ammunition and devote the additional revenue to health care;
- limit the employer/employee tax deductibility for health care coverage;
- means-test the Administration's planned new entitlement subsidies for many individuals and small businesses that may be able to afford their own coverage -- including the proposed subsidy to early retirees;

- postpone expanding Medicare benefits until universal access is achieved for the non-Medicare population; and
- ask upper-income Medicare beneficiaries to contribute toward the cost of Medicare Part A coverage through premiums and to pay a larger part of Part B coverage.

- **Replacing top-down, formula-driven global budget caps with targets or goals,** plus an independent commission to balance promised benefits with available resources

The AHA strongly opposes global budget approaches that are arbitrary and have no relationship to patient needs. There must be a direct link between promised health benefits and the costs of providing those benefits, as well as flexibility to respond to changing health spending needs. Instead of acting as rigid caps on the rate of increase in private-sector health care premiums, global budget targets could serve as a measure of annual health spending increases for publicly subsidized health care expenditures -- those directly subsidized by government appropriations, and those indirectly subsidized through the provision of tax-free benefits.

Global budget targets should be flexible and take into account the health needs of the population, changes in demographics, technological advances, and other factors that an independent national health commission determines are appropriate. If health spending increases exceed the global budget target in a given year, it would be the job of the independent commission to recommend the tough choices necessary to balance public resources available for health care, and publicly funded and subsidized health services.

Such an independent commission could be modeled after other successful independent government bodies such as the Federal Reserve Board, the Defense Base Closure and Realignment Commission, or the Securities and Exchange Commission.

CONCLUSION

In closing, Mr. Chairman, I end where I began. AHA has laid out its principles for health care reform, and these will be the ruler against which we will measure any reform proposal. These principles came about because America's hospitals have been diligent and determined in their wish to play a positive role in the health care reform debate.

Hospitals, perhaps more than any other community organization, understand that no national health care reform effort can be successful unless it works at the local level, where care is actually delivered. We place the interests of our patients and our communities above all others. And that is why we have come up with the proposals I've just related to you -- proposals that, we firmly believe, are in the best interests of our patients, our communities, and our nation.

Mr. Chairman, we aren't simply shooting down other people's proposals where they disagree with our goals. Instead, we are offering well thought-out solutions that we believe can help bring about true reform. We have based those solutions on our experience at the front lines of health care delivery. We bring them to this subcommittee with every hope that they will be helpful as you and your colleagues take your place on the front lines of health care reform.

Chairman WILLIAMS. Thank you, Mr. Flink.

Our next witness is Dr. Charles Duvall, who is an internist and is here representing the American Medical Association.

You are kind to accept our request to come by. Thank you.

STATEMENT OF DR. CHARLES P. DUVALL, INTERNIST, WASHINGTON, DC, ON BEHALF OF THE AMERICAN MEDICAL ASSOCIATION

Dr. DUVALL. Thank you very much, Mr. Chairman and members of the subcommittee.

I am a practicing internist right here in Washington, DC, and I am also a member of AMA's Council on Legislation. We really appreciate the opportunity to give our comments on health care system reform.

As you know, the AMA is committed to working towards a goal of comprehensive, universal health care, with a standard benefit package. We support both employer and individual mandates as well as the creation of medical savings accounts.

Universal coverage, however, is just the initial issue. As physicians, we know the importance of addressing the critical concerns that affect the sanctity of the doctor-patient relationship in a climate that is increasingly dominated by the presence of corporate entities concerned more with profit—and to use your metaphor, Mr. Chairman—concerned more with profit than with what is really going on at the bedside.

Managed care plans now are the dominant models by which patients receive medical services. However, they often fail to consult with practicing physicians about many issues, such as patient care, administrative procedures, medical review, coverage, or other financial matters. Policy is mandated by administrative directive, which often drives medical review and coverage decisions.

To address this, physicians must be given greater responsibility in this new corporate health care arena to make determinations regarding both the quality and the cost components of medical care. Physicians must be legally permitted to exercise their knowledge on behalf of patients and furnished appropriate incentives to take on such a role.

Physicians must be given the opportunity to create and to operate health care plans and delivery networks. They must also be assigned a role in providing essential input into the administrative, procedural, and coverage decisions of commercial health plans not directed by physicians.

Without safe harbors, physicians are severely inhibited from proceeding by the ominous prospect of protracted Federal investigation, draconian civil and criminal sanctions, and egregiously expensive attorneys' fees. Participating physicians in a health care plan must be authorized to develop position statements and recommendations on issues associated with their relationship with both the health plan and its enrollees, our patients.

Legislation is needed to direct the purely commercial plans to create professional committees to provide input on coverage issues, medical review criteria, criteria for credentialing of physicians, administrative procedures, physician payment, and many other matters.

Mr. Chairman, physicians have the knowledge and the training that best qualifies us to be accountable for decisions concerning the management and delivery of optimal patient care. Our close patient relationships allow us to serve in this unique capacity. To do this, though, we need antitrust reforms to enable us to continue to be the guarantors of quality, our historic role as patient advocates. This is the place that we are really the most comfortable.

In addition to this message concerning quality, it is essential that reforms relating to ERISA be incorporated into any health care system reform proposal. Absent compelling financial justification, ERISA plans should not exclude or restrict coverage on the basis of illness or condition, as you well know they unjustly have done on too many previous occasions.

A vigorous fee-for-service sector must be a central feature of health system reform, and without it we will have no safety valve for patient care. It is indeed the acid test of quality in a managed care environment, and the word "choice" has no meaning without it.

We are also concerned about graduate medical education and workforce planning issues. Positive incentives should be employed to increase the number of physicians in primary care in underserved rural and in urban areas. We must, however, maintain freedom of choice for medical students in choosing their careers, as is true for all other professions.

In conclusion, the AMA appreciates the opportunity to appear before all of you, and we stand committed to our overriding goals: the ability to provide access to high-quality medical care to all Americans and the preservation of the sacred physician-patient relationship. We recognize that the vision of health system reform that we support is of the greatest historic significance, and we look forward to working with you in this great endeavor.

Thank you for the chance to appear before you. I will be happy to respond to any questions that you have.

[The prepared statement of Dr. Charles P. Duvall follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Labor-Management Relations
Education and Labor Committee
United States House of Representatives

Presented by
Charles P. Duvall, MD

RE: Health System Reform: Provider Perspective

February 10, 1994

Mr. Chairman and Members of the Subcommittee:

My name is Charles P. Duvall, MD. I am an internist and clinical oncologist from Washington, DC, serving as a Clinical Professor of Medicine at Georgetown University. I am also a member of the American Medical Association's (AMA) Council on Legislation. Accompanying me is Hilary E. Lewis, JD, of the AMA's Division of Federal Legislation. On behalf of the AMA, I am pleased to have this opportunity to testify regarding the sweeping changes that will be effected through reform of the nation's health care delivery system. While we are here today to discuss these issues from the perspective of those who render medical care, the medical profession remains focused on its historic, traditional, and paramount concern -- the ability to provide access to high quality, affordable care to all of our patients. The AMA is committed to working toward a goal of universal coverage for all Americans under a standard comprehensive benefit package.

Both the current and future environment of the health care marketplace presents a great challenge to physicians, hospitals, other health care providers, and especially to lawmakers, to

confront the major issues that will determine whether this nation will maintain its reputation in offering the finest health care system in the world. As physicians, we believe that it is imperative to address the critical concerns that affect the practice of medicine in a climate that is increasingly dominated by the presence of corporate entities concerned more with profit than appropriate medical care. The formidable resources and size of such organizations provide an unfair advantage that works to the detriment of individual practitioners and their patients. More importantly, this atmosphere threatens to diminish the quality of medical care received by the many patients enrolled in the various types of managed care organizations now in operation.

The AMA looks forward to sharing our views on these issues with the Subcommittee and believes that this open discussion will enable us to cooperatively arrive at the most constructive approaches to resolving the complex matters before us as the next century in medicine draws near.

PHYSICIAN INVOLVEMENT, QUALITY, AND ANTITRUST

In the past, health care finance and delivery in the U.S. was organized around the traditional indemnity health insurance plan which allowed patients freedom of choice of physician, as well as the ability to decide, in consultation with the physician, the course of treatment that best suited the patient's needs. The physician could act, in fact was ethically required to act, in the important role of patient advocate. Today, however, managed care plans, such as preferred provider organizations (PPOs) and health maintenance organizations (HMOs), are the predominant models by which patients receive medical services. Increasingly, these plans will be controlled by large, for-profit corporations, such as insurance companies, hospital holding companies, and even corporate sellers and suppliers of medical equipment. Most major legislative proposals addressing reform of the present health care system, at both the federal and state level, recognize this development by contemplating a regulated managed competition structure, with managed care plans seizing an ever-increasing portion of the market.

Under any new framework, health care providers will be expected to work cooperatively to create entities capable of rendering efficient, cost-effective and quality health care. However, large corporate plans often fail to consult with their participating physicians about patient care, administrative procedures, medical review, coverage, or financial issues. Policy is mandated by directive, and non-physicians often drive medical review and coverage decisions. Corporate profits and quarterly dividends become important considerations.

The AMA urges the Congress and the Administration to assure that physicians, as experienced and trained medical professionals, be given greater responsibility in the new corporate health care arena to make determinations regarding the quality and cost components of medical care. To accomplish this task, physicians must be legally permitted to exercise their knowledge on behalf of patients and also be furnished appropriate incentives to take on such a role. Physicians must be given the opportunity to create and operate health plans and health care delivery networks. They must also be assigned a role in providing informational input into the administrative, procedural and coverage decisions of non-medical financial health plans. Legal, regulatory, and economic obstacles now preclude physicians from pursuing this course of action, to the detriment of patients and providers. These barriers preclude the creation of health care entities that could, in fact, contribute to lowering the cost of the nation's medical bill.

1. <u>The Chilling Effect of Antitrust Law</u>

In order to realize the full potential of the role that the medical profession will be expected to assume in the present and emerging health care climate, physicians must be free to organize health care delivery networks, and they must have meaningful input with non-physician networks. They must be granted the legal capacity to negotiate with managed care plans on a variety of issues without the threat of civil or criminal antitrust sanctions. Large insurers promise to continue their domination of the market as only they possess sufficient capital necessary to start a viable new health care

delivery network or plan. Managed competition, however, should provide that physicians be given the ability to participate and accordingly compete with the major corporate players who face far fewer legal obstacles in the formation of health plans. Physician participants in any health plan should have the ability to respond collectively, without engaging in price-fixing, boycotts, or the threat of boycotts. This is especially important in the case of clinical decisionmaking.

The current statutory and regulatory framework militates against the ability of physicians to effectively represent patients by crippling their efforts to organize health care delivery networks, notwithstanding the fact that some of the best performing networks have, in fact, been operated by physicians. Restrictive state insurance and managed care laws, federal and state securities laws, antitrust laws, and federal tax and employee benefit laws and regulations hinder the formation of such networks. Moreover, under traditional antitrust legal analysis and enforcement activities of both the Federal Trade Commission (FTC) and the Department of Justice (DOJ), physicians who have attempted to negotiate collectively with third-party payers through a professional organization or a joint marketing venture have been subjected to criminal investigation and/or civil penalties.

2. Legislative Solutions

To address the foregoing concerns, the AMA strongly urges clarification of the antitrust laws to facilitate the establishment of physician-sponsored health care delivery networks. This objective can be achieved through enactment of H.R. 3486, the "Health Care Antitrust Improvements Act of 1993," sponsored by Representative Bill Archer (R-TX). This measure would establish safe harbors from the application of the antitrust laws for certain activities of health care providers, as long as the venture does not exceed 25 percent of the total number of providers in the relevant market. H.R. 3486 would enhance patient safety by permitting activities of a medical self-regulatory entity with respect to standard setting and enforcement efforts designed to promote the quality of health care, including medical society peer review, accreditation, technology assessment and risk management,

and the development and implementation of clinical practice guidelines. Cost containment initiatives could be effectively pursued through the provision allowing health care providers to participate in written surveys of prices of services, reimbursement levels, compensation and benefits of employees, with any dissemination of survey results released in an aggregate manner so that certain provider-specific information remains confidential. The bill also encourages programs designed to achieve economies of scale and technical efficiencies by creating a safe harbor for activities of a health care cooperative venture with respect to the purchase, operation, or marketing of high technology equipment, as long as the number of participants in the venture does not exceed the total amount necessary to form the venture. Flexibility and efficiency will result through the implementation of joint purchasing arrangements and hospital mergers of institutions having 150 or fewer beds and operating at 50 percent capacity, in order to eliminate the wasteful use of health care resources.

The "Health Care Antitrust Improvements Act of 1993" would also facilitate the formation of health care provider network joint ventures by precluding a finding of "illegal per se" under the antitrust laws for networks that meet certain size and financial risk-sharing qualifications. In the case of nonexclusive networks, in which health care providers may contract with other plans, the number of providers in the venture must represent no more than 50 percent of those in the relevant geographic market. For exclusive networks, in which health care providers are prohibited from participating in other ventures, the number of providers in the network must comprise no more than 35 percent of those in the relevant market. The conduct of such networks would be judged according to a standard of reasonableness by which all relevant factors affecting competition will be considered and evaluated. These networks also will be adjudged by a rule of reason if each member of the venture assumes substantial financial risk in its operation, through the acceptance of capitation contracts, contracts with fee withholding mechanisms relating to the fulfillment of goals for utilization management and review, and, most importantly, the holding by members of significant ownership or

equity interests in the venture itself. If the conduct of the health care provider network joint venture is subjected to antitrust scrutiny, civil monetary penalties will be limited to actual damages, rather than the statutorily permitted treble damages.

The AMA strongly urges the enactment of H.R. 3486, especially inasmuch as the September 15, 1993 "Statements of Enforcement in the Health Care Area," issued by the Department of Justice and the Federal Trade Commission, failed to clarify the parameters of permissible activity for health care provider networks. Without express guidelines outlining the safety zones for the formation of such ventures, prospective joint venturers will be severely inhibited from proceeding by the ominous prospect of protracted federal investigation, draconian civil and criminal sanctions, and egregiously expensive attorney fees. All of these threats act to squelch creative initiatives on the part of physicians and other health care providers to deliver high quality, efficient, and cost-effective medical and health care.

3. Antitrust and Quality Assurance

Physicians are being called upon to serve an equally important function in a health care marketplace characterized by large insurance companies, managed care entities, and other corporate organizations that are rapidly altering the face of the current system. In this increasingly impersonal business environment, their traditional role as guarantors of quality health care will erode unless the legislative and regulatory structure is modified to permit physicians and other health care providers to take an active part in the operation and management of non-medical financial health plans.

Participating physicians in a health plan must, therefore, be authorized to develop position statements and recommendations on issues connected to their relationship with both the health plan and its enrollees. To further this goal, the AMA recommends enactment of legislation directing non-health care provider sponsored health plans to create committees of those health care professionals participating in the plan to provide informational input regarding coverage issues, medical review

criteria, criteria for the credentialling of physicians, administrative procedures, physician payment, and other matters. Although the plan need not be mandated to accept such input, it should be required to consider the recommendations in good faith and provide detailed rationale for rejecting such advice. Physicians have the expertise, experience, and close relationship with their patients to serve in this unique capacity. Their knowledge and training best qualifies them to determine the tests and procedures that are essential to the management and delivery of optimal medical care, and to stand accountable for their decisions. Statutes and regulations must not constrain the medical profession from performing this critical function.

ERISA REFORM

From the perspective of health care providers, it is essential that reforms relating to the Employee Retirement Income Security Act (ERISA) be incorporated into any health system reform proposal. The AMA believes that all employee health benefit plans -- both insured and self-insured -- must offer a standard set of benefits that meet federal guidelines. These plans must be portable, community rated, equitably administered, and offer improved beneficiary legal remedies, including additional state hearing and federal remedies, and access to an early dispute resolution process.

Under ERISA's current federal scheme, which widely preempts the application of any state tort laws or other laws relating to health benefits, self-insured plans have been free to discriminate against patients suffering from illnesses requiring expensive medical care under the guise of cost containment. The ruling in Greenberg v. H & H Music Co. in which an employer was permitted to cut benefits from a lifetime cap of $1 million to only $5,000 for any HIV-related illness demonstrates the clear need to amend ERISA. Although the Americans With Disabilities Act (ADA) promises some relief from this kind of blatant discrimination, the application of the ADA law remains unclear. The AMA strongly supports ERISA reform to establish that, absent compelling financial justification, ERISA plans cannot exclude or restrict coverage on the basis of illness or condition.

Similarly, self-insured plans should not be able to continue to discriminate against beneficiaries by refusing to pay benefits. The federal scheme that is now in place allows plans to engage in this kind of bad faith activity due to insufficient legal protections for beneficiaries. The AMA recommends amendment to ERISA to prohibit these actions and create expanded legal remedies for those whose rights have been violated by the unencumbered acts of self-insured plans.

PHYSICIAN PAYMENT UNDER HEALTH SYSTEM REFORM

The AMA believes that a vigorous fee-for-service sector must be a central feature of health system reform. Fee-for-service is essential to the choice that patients and physicians have been promised by the Clinton Administration. It is also integral to the managed competition framework that informs H.R. 3600, the Health Security Act -- fee-for-service sets the standard against which to measure all other health plans. Without a viable fee-for-service sector, our health care system will lack any true safety valve for meeting patients' highly personal health care needs.

"Fee-for-service" and "choice" are intended to be key elements of the Health Security Act. Under H.R. 3600, the Health Security Act, each health alliance would be required to offer at least one fee-for-service plan, and we applaud this explicit fee-for-service recognition. The AMA commends the bill for restricting the ability of alliances to limit the number of fee-for-service plans and placing an increased emphasis on "point-of-service" mechanisms to enhance choice. Unfortunately, H.R. 3600 still does not comport with patients' concept of choice nor with how fee-for-service enhances choice.

Patients' preference for fee-for-service medicine has greater meaning than simply paying a doctor for each service. They want to choose their own physicians, and to switch to another if dissatisfied. They want their doctor to be paid for providing care, not for withholding it. They want talent and judgment to be rewarded, and they also want personalized service, and stable doctor/patient

relationships. They want their doctor to work for them to advocate their interests, not those of a health plan. Although many physicians and patients participate in managed care plans, they are exercising their choice to do so. The AMA is concerned that the Administration's plan will create an environment in which meaningful patient choice, in all of its dimensions, is diminished.

While the Administration recognizes that all Americans should be able to join a fee-for-service plan, the plan's "fee-for-service" option may not afford our patients the choices they want, at a price they can afford.

There may be only one fee-for-service plan in an area, and in some situations, none. Only requiring alliances to offer one fee-for-service plan could lead to inferior service and lack of innovation, with no competition from other fee-for-service plans. If no fee-for-service plan proposes a premium within 20 percent of the average premium in the alliance area, the alliance would have the option of not offering a fee-for-service plan.

Fee-for-service plans will be under strict annual, plan-level global budgets. To stay within these annual budgets, and to remain premium competitive and solvent, some fee-for-service plans may be forced to restrict care and slash physician payments. These pressures will be particularly severe under the fee-for-service option called "*prospective budgeting.*" Patients and physicians, believing they have chosen a fee-for-service plan, may find themselves in a setting more restrictive than in managed care plans.

Physicians will be forced to accept state or regional "fee schedules" as payment in full. Payment for fee-for-service physician services, as well as "out-of-network" care in non-fee-for-service plans, would be according to a fee schedule established by each alliance or state. Balance billing would be prohibited in all health plans, with more restrictive constraints than now applied for Medicare. Fee-for-service would face rigorous price controls. While physicians would be permitted to "collectively negotiate" the fee schedule with alliances or states, the plan does not specify that negotiations must be in "good faith" or subject to formal impasse resolution mechanisms, such as binding arbitration. With no billing ability beyond the "negotiated" amount, there will be no means to reward or pay for superior services or special expertise.

A New Approach to Fee-For-Service

The Health Security Act provides a starting point for a vigorous fee-for-service sector, but it requires several changes to meet this objective. In the AMA's view, all viable health system reform proposals should embody the following six principles, which provide a *new approach to fee-for-service* that offers Americans real choice and elevates the physician/patient relationship to the highest value in the health care system:

1. There must be advance disclosure of physician fees, all other provider fees and charges, and plan payments. Fee-for-service physicians will offer the cost predictability that is often cited as a hallmark of managed care. Patients will use fee information to help choose a physician, use plan payment levels to choose the plan with the best coverage, and use both to estimate out-of-pocket costs. The proposed requirement for each health plan to report on costs, quality, and other relevant factors provides a ready vehicle for fee-for-service plans and their physicians to provide fee and payment information.

Under the Administration's approach, the National Health Board (NHB) should encourage states, alliances, and plans to consider using the resource-based relative value scale (RBRVS) as the basis for their fee schedules. The RBRVS, now being used for Medicare services, is on a rapid path toward completion (i.e., values are being developed for services provided to non-Medicare patient populations) in 1994 and continues to be refined. It would provide a needed standardized basis for fee and payment schedules. It would also facilitate physician fee disclosure and plan disclosure of payment levels. Physicians and payers would establish their own, well-publicized dollar conversion factors, which would be the basis for simplified fee and payment comparisons by patients.

The eminent health economist and member of the Physician Payment Review Commission, Professor Uwe Reinhardt, has recently endorsed this general strategy, concluding that ready availability of comparative price information "probably would drive health care prices toward greater uniformity and acceptable levels, even without explicit rate regulation." Recently, Maryland enacted health system reforms mirroring much of this proposal.

2. Physicians' fees should not be regulated by the government or by health alliances. There should be no absolute ban on balance billing, which should be an issue for negotiation between physicians and states and/or alliances and health plans, and should be allowed if physicians have not contracted or negotiated otherwise. Where balance billing is allowed, this becomes a matter of discussion between the physician and an informed patient. Also, there should be no balance billing for Medicaid recipients and persons with incomes below 200 percent of the poverty level.

Arguments for price controls are made obsolete by fee and payment disclosure and by alternatives to fee-for-service. The real, if often hidden, costs of price controls are predictable -- longer waits, shorter visits, and restricted technology. In contrast, "managed balance billing," as outlined under Principle 1, allows for variations in physicians' practice expenses, expertise and quality. It provides a safety valve to protect access and physician participation in fee-for-service if allowed payments are insufficient and if fee-for-service plans must restrain payments to compete with other plans.

3. There should be two or more affordable fee-for-service plans offered on an annual basis by each employer or health alliance. In all but the most extreme circumstances, each alliance must have at least one fee-for-service plan. Each alliance should be required to make an annual good faith effort, to ensure at least two fee-for-service plans in its area, so that managed competition serves both fee-for-service and managed care. Competition among multiple fee-for-service plans will help guarantee acceptable service for patients and physicians and beneficial innovations in plan operations.

4. There should not be annual regulated budgets for fee-for-service plans. Both strict premium regulation and prospective budgeting make the fee-for-service plans into *"de facto"* HMOs. Certainly fees outside plan allowances should not be under the budget. If patients choose to make such unsubsidized payments, they should be free to do so.

5. There must be meaningful negotiations over payment levels. It is essential that physician organizations can represent physicians in the required "collective negotiations" over initial and annually updated payment schedules. These negotiations must use formal impasse resolution mechanisms, like binding arbitration, and alliances should be required to negotiate in "good faith." (As discussed previously in this statement, the AMA is also pursuing broader antitrust relief to achieve fair and cost-effective relationships between and among plans and physicians.) In addition, individual fee-for-service plans should be able to negotiate payment schedules with physicians. Otherwise, they will have little incentive to develop innovative ways to reward physicians for lower use of physician, hospital, and other health care resources.

6. The ability of point-of-service options to strengthen choice should be enhanced. We strongly support the "combination cost sharing" approach in the Health Security Act, as well as the requirement for "low cost sharing" plans to offer a point-of-service option. These options, which permit out-of-plan care, will augment the fee-for-service plans in supporting a vigorous fee-for-service sector that enhances patient choice. A balance must be struck, however, between encouraging real choice through point-of-service options and creating a profound and artificial competitive disadvantage for the fee-for-service plans. Both the higher cost sharing (i.e., fee-for-service) and combination cost sharing (i.e., PPO) point-of-service benefit packages involve the same coinsurance and deductibles. This will severely threaten the fee-for-service plans. Thus, the coinsurance level for the combination and low cost sharing plans should be above 20 percent.

MEDICAL EDUCATION AND PHYSICIAN WORKFORCE

Turning to the subject of medical education, the AMA very much appreciated the opportunity to work with the Education and Labor Committee on the reauthorization of the Higher Education Act in 1992. We commend the Committee for its efforts to ensure the inclusion of fair and equitable provisions in the legislation relating to regulation of voluntary accrediting agencies, as well as to deferment and forbearance on repayment of education loans for persons in medical residency training programs. Several other medical education matters require similar attention.

Graduate medical education and workforce planning issues are of utmost concern to the AMA, especially to our many medical student and resident physician members. Most importantly, the AMA believes the profession must be centrally involved in addressing physician numbers, specialty mix and geographic distribution. Federally dictated workforce planning, particularly through the introduction of federal mandates into our private and state educational systems, could have potential negative effects. In our view, positive incentives should be employed to increase the

number of primary care, minority, and rural physicians. These positive incentives should emphasize physician satisfaction with practice and practice locations, appropriate role models for physicians in training, lifestyle issues, loan forgiveness and other financial incentives, and physician reimbursement.

1. Increased Training of Primary Care Physicians

In order to attract more individuals to seek careers in primary care, the AMA supports establishing a national priority and appropriate funding for increased training of primary care physicians. However, we concur with the majority of workforce analysts who now agree that workforce planning should be based on physician-to-population ratio data, not arbitrary specialty mix percentages such as 50/50 or 55/45. In addition, workforce planning must also consider such other factors as regional variations, differences based on physicians' length of time in practice, gender-based practice differences, and utilization by certain practice models. For example, the experience of group and staff model HMOs in this country indicates utilization in the range of only 60 primary care physicians per 100,000 individuals.

Additionally, the AMA believes that freedom of choice for medical students in choosing a specialty and career in medicine, as for any one else in any other profession, must be maintained. Thus, we oppose granting the federal government nearly total control over graduate medical education by establishing a fixed ratio of primary care to nonprimary care physicians, as called for in H.R. 3600, the "Health Security Act," and in other bills.

While medical schools should be permitted to define their own missions, incentives should be created to increase the production of primary care physicians. Schools should be encouraged to develop mentoring and other programs to motivate students to enter a primary care field, and they should monitor the ultimate specialty choices and practice locations of graduates to assess the attainment of their stated missions.

While we believe that attempts must be made to attract more individuals to primary care careers, we also would suggest that the current specialty mix percentages, as widely reported, do not portray a perfectly accurate representation of the practice environment. We maintain that physicians cannot be unambiguously categorized as either "primary care" or "nonprimary care" practitioners. In reality, one-third of the U.S. physician population practices in more than one specialty, and many of these physicians provide both primary care and nonprimary care services.

Many of the analyses of physician workforce issues utilize data from the AMA Physician Masterfile, which is the only database providing a complete enumeration of the entire U.S. physician population. Most of the Masterfile's information on the specialties in which physicians practice is provided by the physicians themselves. The AMA periodically surveys the entire physician population, sending each physician a questionnaire that includes a question asking physicians in which specialt(ies) they practice. Physicians may respond with as many as three specialties, and for each, they are asked to report the number of hours they practice during a typical week. The specialty in which a physician practices the greatest number of hours is designated as the physician's primary specialty.

Analysis of data derived from the AMA Masterfile as of January 1, 1992 indicates that for certain subspecialties categorized as nonprimary care, the blending of primary and nonprimary care services rendered is quite high. For example, seven out of every nine medical subspecialists provide (what is characterized as) some primary care. Similarly, over two-thirds of pediatric subspecialists provide some primary care. While more primary care physicians are needed, we cannot lose sight of the fact that many physicians outside of the designated specialties do provide at least some primary care.

The high cost of medical education, and the significant debt that many medical students face at the time of graduation, may influence specialty choice. Scholarship and loan repayment programs,

already existing at the national and state levels, should be expanded. Qualified students from rural or urban underserved areas and minority students should be especially recruited and supported. Experience has shown that there is a greater likelihood for students from such backgrounds to return to the root (or a similar) community upon completion of medical training.

Support should also be provided for medical schools to introduce or intensify education programs associated with the choice of a primary care career, such as family medicine clerkships, patient longitudinal primary care experiences, and preceptorships with practicing physicians. Primary care physicians should be more fully integrated into the medical school as teachers, career advisors, and members of key academic committees. The academic base of primary care physicians should be fortified as well. Increased funding for research in primary care represents a key strategy for achieving this objective. The scholarly activities of these disciplines and the scientific stature of the primary care physician would be immeasurably reinforced. Along these lines, the AMA now publishes a peer reviewed journal in family medicine.

A number of factors have been cited as influencing the choice of a primary care career. Strategies to focus student interest in primary care should be directed at a variety of targets, including the medical schools, the residency programs, those bearing responsibility for financing health care, and the entire practice environment. For any action to have a significant chance of success at increasing the number of primary care physicians, it must form part of a comprehensive program addressing matters such as education, health care financing, and the practice environment. Any "solution" must involve a partnership effort between the federal government, medical schools, the medical profession and the community.

2. Other Physician Workforce Issues

The AMA supports an incentive-directed, private sector initiative for workforce planning. Toward that end, the AMA recommends a workforce commission, comprised of both academic and

community physicians, to study and develop recommendations on physician workforce issues. This body would advise the Secretary of Health and Human Services on all issues related to physician workforce planning. Provisions also must be made for appropriate professional input into issues of physician workforce planning, particularly with respect to total numbers of physicians and the mix of generalists to specialists. Antitrust relief in this area is critical to the achievement of this goal.

The AMA has articulated its views on other matters relating to physician workforce issues that have surfaced in various legislative proposals. In determining appropriate numbers and types of physicians, regional differences and needs must be carefully considered, particularly in medically underserved areas. Such an imperative is required especially if there were to be a reduction in the total number of entry positions in approved U.S. medical residency training programs, as was suggested in a number of bills introduced last year. The AMA also questions whether "weighting" of residency positions toward primary care would significantly affect specialty choice. In this regard,the residency accreditation process does not represent an appropriate vehicle for arriving at workforce decisions (for example, ranking residency programs according to quality and using such rankings to allocate residency positions among programs).

Finally, the AMA supports increased federal funding for expansion of the National Health Service Corps to meet access needs in truly underserved areas, as well as the possible use of those sites for experiences in primary care training, with support for teams of physicians and other health professionals working in a supervised, collaborative model, with tax preferences and increased reimbursement as appropriate incentives. We oppose singling out health care professionals for compulsory national service.

3. Graduate Medical Education Financing

We support uniform participation by all payers in the financing of graduate medical education and the elimination of unwarranted variation among hospitals in graduate medical education costs

claimed. Funds for graduate medical education should be allocated based on regional needs. Direct residency funding should include the costs of faculty supervision and other related teaching expenses. Health Care Financing Administration (HCFA) regulations should be modified sufficiently to minimize the vast differences in direct residency reimbursement that have existed in the past, but should not be based on a national average, which could unduly penalize institutions in certain regions while unjustly rewarding others.

In the current practice environment, increasing amounts of health care are being delivered to the citizens of this nation in ambulatory settings. Graduate and undergraduate medical education in ambulatory and primary care settings must be increased, although the proper education of all physicians will still require in-hospital based educational experiences. Determination of the proper balance of ambulatory and hospital-based education of physicians should be done by the nation's medical schools. It is the responsibility of the Liaison Committee on Medical Education to establish standards for medical student education and of the Accreditation Council on Graduate Medical Education and the appropriate residency review committees (RRCs) to establish the standards for graduate medical education (medical residency training).

If more ambulatory training is to be conducted, funding must be available for this activity. Both the current and proposed financing mechanisms fail to provide sufficient funds for such training in a cost-conscious environment. As regards funding to encourage more ambulatory and community-based education on the part of medical schools and residency programs, one obvious source of such funding is the present Medicare indirect graduate medical education payments. Therefore, any revision of the current Medicare indirect medical education formula should take into account the need to support education in ambulatory and community sites. Finally, a mechanism for proper transition funding through the period of time necessary to fully implement an all-payer system should be formulated so that undue financial hardships are not imposed on teaching hospitals.

COVERAGE AND BENEFITS

In 1994, as Congress begins to consider a number of health system reform bills, the AMA is renewing its call for action. In January, 1994, we announced another proposal for advancement of our health system reform agenda, *Providing Health Coverage for All Americans*, which is attached to our statement today. That proposal underscores our commitment to ensure that health system reform builds upon a foundation of universal coverage with a standard set of benefits for every American and affirms the physician's role as patient advocate. Our approach to achieve that goal is multi-pronged.

First, the AMA advocates that all Americans should have access to a standard benefits package. The AMA recommendations, attached to our statement today, include comprehensive coverage for preventive services, based on medically-developed age-appropriate periodic screening guidelines, including immunizations, screening tests, and smoking cessation programs; inpatient hospital care; outpatient care; and other benefits, including outpatient prescription drugs, skilled nursing facility services, and hospice care.

We support tax deductibility of employer/employee-provided health insurance at an appropriate ceiling such as 125% to 133% of the geographically-adjusted costs of the required standard benefits package. We support assistance for smaller firms, including sequential phase-in of coverage requirements, tax incentives to make the provision of a benefits package manageable, a choice of benefit plans in three actuarially equivalent forms as available, including a benefit payment schedule, a pre-paid HMO/PPO approach, or UCR plans, and the incorporation of meaningful patient cost-sharing (except for preventive care) to encourage prudent health care decisions.

To advance universal coverage under a standard benefits package, the AMA supports a variety of financing approaches, including an employer mandate, an individual mandate, and use of health IRAs or medical savings accounts (MSAs). While the AMA continues to support a requirement for employers to contribute to the financing of health care coverage for employees, we

also advocate flexibility in emerging health system reform policy to determine the relative responsibilities of individuals, employers, and government in achieving universal coverage. We have not endorsed any health system reform legislation, but we believe that all approaches, including the President's employer mandate in S. 1757 and H.R. 3600 and Senator Chafee's and Representative Thomas's individual mandate, as expressed in S. 1770 and H.R. 3704, should be evaluated. We believe legislation to establish MSAs can also be effectively integrated into a health system reform that meets our goal of universal coverage.

CONCLUSION

Mr. Chairman, the task before us is a daunting one. The AMA and the medical profession, however, stand committed to our overriding goal -- the ability to provide access to high quality, affordable care to all of our patients, and the preservation of the physician/patient relationship. We recognize that the health system reform vision we support and will undertake with you is of historic significance. We look forward to working with you to meet this challenge so that universal health care coverage becomes a reality.

The AMA appreciates the opportunity to appear before the Subcommittee. At this time, we will be pleased to respond to questions.

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American Medical Association
Physicians dedicated to the health of America

Providing Health Coverage for All Americans

Health System Reform Proposal for Action

January 1994

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Health System Reform Proposal for Action

In 1990, the American Medical Association (AMA) called for comprehensive health system reform in its proposal, "Health Access America". We're still waiting for action. Many Americans are still shut out of our health care system; millions of others face the problem of staying in a job simply because it offers decent health insurance; others are financially ruined because of devastating health care expenses. Changes in the marketplace are also jeopardizing patients' freedom to reach health care decisions with their physicians and replacing physicians' clinical judgment and decision-making expertise with corporate cost-cutting concerns.

To remedy these problems, the AMA urges Congress to pass a health system reform bill that: (1) has as its centerpiece universal coverage for a standard set of health benefits for every American, regardless of employment or economic status; (2) creates a health care system where competitive forces act to constrain rising health care costs; and (3) affirms the physician's role as patient advocate. We present this current reform proposal to accelerate legislative debate and action. We pledge to work with the Administration and the Congress in 1994 to advance these goals.

Our proposal also recommends a significant role for physicians as patient advocates in shaping policy, health care payment and delivery decisions under a revamped health system. If physicians are going to be successful advocates for their patients in ensuring access to high quality, affordable health care, they must have a strong voice on issues relating to the delivery of and payment for care. In managed care and other delivery arrangements, patient-physician decisions must prevail over economic considerations.

The AMA reform proposal is intended to:

- Achieve universal health care coverage for all Americans;
- Strengthen the voice of physicians in clinical judgment and decision-making to balance the ever-increasing corporate domination of health care;
- Promote compromise and flexibility to achieve universal coverage and to design the best approach to shared responsibility of employers, individuals, and government in paying for health care coverage;
- Slow the rate of growth in health spending through competition in the marketplace;
- Effect major professional liability reform to reduce the inappropriate cost of defensive medicine and liability insurance premiums;
- Assure that all Americans have choice of health plans and physicians;
- Provide individuals with price and quality information to make informed health care decisions; and
- Create a more efficient, streamlined, and coordinated health care system.

Our proposal recommends the following fundamental changes to our health care system.

Universal Coverage

Health care coverage must be extended to all Americans. We support a variety of approaches to achieve this goal: an employer mandate, an individual mandate, and health IRAs. As the congressional debate unfolds, flexibility will be needed in determining the relative responsibilities of individuals, employers, and government to ensure universal coverage with a standard set of health care benefits for all Americans.

Insurance Market Reform

To ensure that insurance carriers can no longer deny coverage to individuals with chronic or other medical problems, or refuse to renew such coverage -- and to even out the affordability of health insurance premiums -- the following insurance market reforms are essential:

- Implement community rating; and
- Eliminate pre-existing condition limitations so individuals with chronic or other medical problems can secure and keep private health insurance.

Health Insurance Purchasing Cooperatives

- The insurance market reforms we advocate are similar to those that have worked successfully in Hawaii; specifically community rating, elimination of pre-existing condition clauses, and portability of coverage. To the extent these reforms are adopted -- particularly community rating which would make insurance available to all at no more than a community-established premium -- then health insurance purchasing cooperatives would serve primarily to disseminate information to the public. Without such insurance market reforms, voluntary private sector health insurance purchasing cooperatives are desirable so that small firms and individuals can benefit from the market power of group purchasing. Under such a purchasing cooperative approach, competing cooperatives in the same geographic region are essential to ensure that no one giant purchasing conglomerate could monopolize the market, thereby reducing competition and consumer control of health care decisions.

Physician Involvement in The Health Care System

Antitrust Relief
Physician-Directed Networks
Negotiated Rulemaking
Self Regulation

Today's health care marketplace is increasingly characterized by corporate, and often for-profit, organizations and large managed care plans that are taking aggressive action to control the delivery of health care services and reduce their costs. While efforts to save costs are appropriate and

desirable, excessive concern for costs can interfere with the availability and delivery of health services to patients and diminish the quality of those services.

If physicians are going to be successful advocates for their patients in ensuring access to high quality, affordable health care, they must have a strong voice on issues relating to the delivery of and payment for care to balance the ever-increasing corporate domination of health care.

Under the current antitrust laws, however, physicians who engage in negotiations are threatened with criminal prosecution or costly civil litigation. This state of affairs is simply unacceptable as a matter of health care policy and fundamental fairness. To correct this situation and to foster meaningful reform whereby treatment decisions are made on the basis of what is best for the patient -- not what is best for the corporate bottom line -- we propose the following:

- Enact legislation that facilitates the formation of physician sponsored/directed health care delivery networks and health plans. This legislation should authorize physicians to form these entities and provide exemptions from regulations that interfere with this activity.

- Reform the antitrust laws to allow for safe harbors similar to those developed by the Department of Justice and Federal Trade Commission, but expand the safe harbors for the formation of physician groups representing up to 35% of the physicians in a market in exclusive networks, and 50% in nonexclusive networks. Such percentages may need to be adjusted upward in rural areas.

- Enact legislation to direct non-physician sponsored health plans to create committees, similar to a hospital medical staff, of practicing physicians in the plan to provide input about coverage, medical review criteria for individual coverage decisions and credentialing of physicians, administrative procedures, physician payment, and other matters. The legislation would recognize the right of physicians to make presentations to health plans that has been provided for in federal judicial decisions.

- Legislation also should be established under federal law for negotiated rulemaking, backed up by binding arbitration for dispute resolution, as the primary method for developing federal health care regulations, with the AMA acting as the profession's lead negotiator. Such mechanisms would not establish -- nor would it be to the benefit of patients or physicians to establish -- any "right to strike" by physicians.

- Standard setting should be performed by physician organizations in such areas as the development of practice guidelines, outcomes measurement and reporting, and performance standards. The development and application of standards for medicine is an area where the profession has excelled, particularly in the accreditation of medical education and health care institutions. This method is highly effective on a performance and cost basis. As part of this, medical societies should be allowed to conduct medical peer review activities and mediate fee disputes between patients and physicians for purposes of professional self regulation and discipline.

Professional Liability Reform

Defensive medicine, the ordering of tests and procedures which might not be ordered were it not for liability concerns, drives up health care costs. Liability insurance premiums and defensive medicine activities add significantly to the average physician's bill for services. According to Lewin/ICF, the cost of defensive medicine activities performed by physicians totaled $25 billion in 1991. These unnecessary costs are passed on to patients and contribute to rising health care spending.

Major liability reforms -- similar to those enacted in California in 1974 -- must be enacted to control these costs. California's experience has proven that such reforms significantly reduce physician's liability insurance premiums. Prior to enactment of California's liability reforms, physician's professional liability premiums were roughly equivalent in California and New York. Today, physician's average liability premiums are about 40 percent higher in New York than in California, with differentials of up to three to five times in some specialties (such as obstetrics and neurosurgery).

Our proposal specifically recommends:

- A $250,000 cap on noneconomic damages;
- Mandatory periodic payment of future elements of damages;
- A mandatory offset of collateral sources, such as health insurance and disability benefits when computing compensation to prevent double recovery of damages;
- A sliding scale limit on attorneys' fees in relation to the size of the award;
- A statute of limitations, applicable to adults and minors, to limit the time period for filing claims;
- A certificate of merit as a prelude to filing medical liability cases and adopting basic criteria for medical expert witnesses;
- Encouragement of patient safety issues as an integral component of outcome and quality assessment programs; and
- Providers following clinically relevant practice parameters developed by professional associations should be allowed to raise such compliance as an affirmative defense in liability actions.

Quality of Care

The quality of health care in the United States remains unsurpassed -- and is one of the greatest strengths of the American health care system. To ensure this continued level of excellence, physicians and their professional organizations should continue to control the standards for quality care delivered to patients. Such standards will help to assure that only appropriate medical services are provided, thus impacting favorably on the quality and cost of medical care.

Our approach presents a public/private partnership to enhance quality, rather than creating any new federal bureaucracy or new systems for accountability that would fail to recognize existing quality improvement and accreditation programs.

Our reform proposal includes:

- A defined role for organized medicine and practicing physicians on any national public or quasi-public body dealing with quality issues;

- A provision for input by the medical profession in the development, implementation, and evaluation of quality management programs at the state and health plan levels;

- A provision for input from consumer and patient representatives about quality issues (e.g., access to performance data, confidentiality of medical records, satisfaction with physicians and other providers);

- Establishment of a private/public partnership to implement a national quality program that strengthens existing private sector efforts in quality, utilization and outcomes management -- instead of government control over quality programs. This partnership establishes a national advisory body on quality of medical care and will provide for the exchange of information among quality programs, oversee the establishment of performance measurement systems, and shall have deemed status to accredit and approve quality programs. The partnership would:

  - Develop principles for quality management;

  - Develop principles for outcomes measurement and reporting, including the content and format of electronic patient records, and guiding and coordinating efforts to gather outcomes data;

  - Develop mechanisms, such as provider report cards, to assure the public availability of information and to inform patients and purchasers about local health plan performance and to promote both quality and competition in the marketplace;

  - Develop interventional tools and education programs to change practice patterns;

  - Develop strategies for and coordinating effectiveness research and technology assessment;

  - Develop principles of utilization management; and

  - Establish priorities for guideline development through analysis of variations in practice.

Freedom of Choice

Currently, too many individuals have only limited choice of health plans offered by their employers and their access to physicians under these plans also is often restricted. In a reformed system, the individual -- not the employer -- should have the right to select from all qualified health plans in their area, including fee-for-service, HMO, PPO, and benefit payment schedule plans. This will ensure that individuals are able to choose both their physician and their preferred method of paying for health care.

Our proposal specifically recommends that:

For Patients

- Individuals shall be entitled to select from any qualified health plan -- fee-for-service, PPO, HMO, or benefit payment schedule -- offered in their geographic area.

- All health plans, including HMOs, must offer individuals the option of purchasing a "point of service" rider. This rider, which must be offered by plans at time of enrollment and at least annually thereafter, would entitle individuals to seek care from any physician -- whether in or out of the plan -- and have coverage for such care as defined in the comprehensive benefit package.

- Any health plan restriction of access to services or providers must be disclosed to and acknowledged by the enrollee.

- All insurers and health plans must pay for case management services/coordination of care delivered by qualified health care professionals to promote more coordination of services across specialties for the benefit of patients.

For Physicians

- Physicians shall have the right to apply to any health plan or network and to have that application approved if it meets physician-developed objective criteria that are available to both applicants and enrollees and are based on professional qualification, competence, and quality of care. However, health plans or networks may develop and use physician-developed criteria to determine the number, geographic distribution, and specialties of physicians needed.

- Managed care organizations and third-party payers shall be required to disclose to physicians applying to the plan the selection criteria used to select, retain, or exclude a physician from a managed care plan, including the criteria used to determine the number, geographic distribution, and specialties of physicians needed.

- Health plans or networks that use criteria to determine the number, geographic distribution, and specialties of physicians shall report to the public, on a regular basis, the impact that the use of such criteria has on the quality, access, costs, and choice of health care services provided to patients enrolled in such plans or networks.

- In any case in which selection criteria, especially economic criteria, may be used for consideration of sanction or dismissal, the physician participating in the plan should have the right to receive profile information and education, in a due process manner, before action of any kind is taken.

- Managed care plans and medical delivery systems must include practicing physician involvement in their health care delivery policies similar to those of self-governing medical staffs in hospitals. Physicians participating in these plans (and no physicians should be arbitrarily excluded) must be able, without threat of punitive action, to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including practicing physician representation on the governing board and key committees of the plan.

Cost Containment

Rising health care expenditures are driven by many factors: inflation, new and expensive technology, and health conditions associated with increasing societal problems such as violence, drug abuse, poverty, and HIV infections. For too many individuals, the rising costs threaten their access to needed services and their ability to pay for medical care.

Our proposal's approach to cost containment focuses on increasing competition in the marketplace. The proposal would foster competition by:

- Encouraging cost-conscious decision-making by patients through the provision of clearly-understandable price information for physician, hospital, and other services and the extent of insurance payment for covered services. Insurance companies and physicians that use a relative value scale methodology could make available to the public their conversion factor and other necessary information so that patients can determine the extent of insurance payment for a particular service;

- Requiring employers and insurers to offer individuals a choice of health plans and financing mechanisms.

The AMA proposal would also:

- Establish a negotiated goals approach -- rather than premium caps or strict global budgets -- that involves physicians in establishing reasonable health care spending goals that take into account demographics, disease, technology, and demand factors.

  - Such a negotiated approach is in direct contrast to strict global budgets or spending caps -- both of which would result in rationing of health care services and would conflict with society's obligation to ensure that no American goes without health care coverage.

- Utilize practice parameters and utilization guidelines to enhance quality, cost-effective and outcome-effective care.

- Establish that for those individuals below 200 percent of the federal poverty level, insurance payment must be accepted as payment in full.

- Effect major professional liability reform to reduce the inappropriate costs of defensive medicine and liability insurance premiums.

- Simplify the system through reduction of paperwork and government regulation and standardization of managed care requirements, claims procedures, review practices, and disclosure policies.

- Create a level playing field for the self-insured and the insured alike through the amendment of ERISA to assure provision of secure, standard benefits and fairness of treatment for all.

- Cap the deductibility of employer-provided health insurance at an appropriate ceiling such as 125 percent to 133 percent of the geographically-adjusted costs of the required comprehensive standard benefit package. This cap would apply to the employer and the employee and would foster prudent use of services and raise needed revenue to fund coverage for currently uninsured and underinsured Americans.

Scope of Practice

The AMA supports appropriate collaboration among physicians and other health professionals within the scope of their education and training to achieve the best results for patient care. Determinations of "appropriate" collaboration should be mutually-developed through interdisciplinary discussions.

Standards for determination of scope of practice for various health professionals should be established at the state level, including provisions that would preclude inappropriate restriction of practice by those professionals demonstrating educational and clinical competence.

Our proposal specifically recommends:

- National studies to identify those programs where physicians, nurses, and other health professionals have been working on a collaborative basis both successfully and unsuccessfully and to disseminate such information broadly.

- These studies should also provide support for the interdisciplinary discussions on a mutually-acceptable definition of "collaborative practice" and for discussion of such issues as reimbursement for services and the identification of advance practice nursing roles in the hospital and community settings.

Physician Workforce

Currently, there are an inadequate number of physicians in primary care specialties. This problem needs to be addressed. Our proposal specifically recommends:

- A private sector consortium/initiative, independent of control by any single group, that would develop positive incentives (e.g., loan forgiveness) to increase the proportion of physicians who enter and remain in primary care specialties and practice in underserved areas.
- Preservation of student and resident freedom of specialty choice -- in contrast to the imposition of workforce quotas and the use of negative sanctions.
- Participation by all payers in the funding of graduate medical education.

Simplifying the System

The current health care system is fragmented, costly, complicated and characterized by duplicative and confusing paperwork and government regulations. To allow more time for patient care activities -- and to improve access and help contain health care costs -- administrative simplification must be a core element of any health system reform initiative. Our proposal includes the following specific changes:

Administrative Changes

- Reduce the complicated paperwork nightmare faced by patients and their families by requiring that all insurers and the government use a simple, uniform claim form.
- Provide incentives to encourage physicians and other providers to file benefit claims on behalf of their patients.
- Provide incentives to encourage health insurers to use a standard electronic billing format and to encourage physicians to utilize this method of filing claims on behalf of their patients.
- Standardize and disclose utilization review criteria to patients and physicians.
- Reduce the regulatory and costly burden of unnecessary government programs.

Financing Reform -- Who Will Pay?

The provision of health coverage to all Americans could be assured through a variety of approaches, such as through a blending of responsibilities of employers, individuals, and the government. There is no single best mechanism. Revenue for expanding coverage to all Americans would be generated by the AMA recommended employee/employer tax cap and an excise tax of at least $2 per pack on

cigarettes. As necessary, additional revenue for financing the government's contribution to universal health care coverage could be raised from broad-based taxes -- rather than inappropriate spending reductions in the Medicare and Medicaid programs.

In Sum, The Time for Action Is Now

This proposal offers a comprehensive solution to reforming our health care system that blends competitive forces in the marketplace with societal responsibilities to ensure affordable health care coverage for all Americans. This proposal would also reaffirm the physician's role as patient advocate and reinstate the patient's right to reach health care decisions with their physician unencumbered by corporate decisions that often place profits above patients.

We call upon all parties to seek common ground in establishing an improved health care system for all. We stand so ready. We strongly urge the Congress to pass a health system bill that: (1) has as its centerpiece universal coverage for a standard set of health benefits for every American, regardless of employment or economic status; (2) creates a health care system where competitive forces act to constrain rising health care costs; and (3) affirms the physician's role as patient advocate. We pledge to work with the Administration and the Congress in 1994 to advance these goals.

Chairman WILLIAMS. Thank you.

Dr. James Weber is from Arkansas and is the president-elect of the American Academy of Family Physicians. Thank you for being here.

STATEMENT OF DR. JAMES WEBER, JACKSONVILLE, ARKANSAS, PRESIDENT-ELECT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. WEBER. Thank you very much.

I am a family physician in Arkansas. It is my privilege, at the present time, to be president-elect of our 74,000 members. On their behalf, I certainly appreciate the opportunity to testify before you this morning, focusing really on the issue of the employer mandate in financing health care reform.

You may know that, in 1989, before this administration even, the Academy of Family Physicians became the first national physician organization to develop a plan for universal coverage of all Americans through a public-private health care reform system. Our plan builds on the current model of employer-based insurance.

The family physicians' access plan calls for universal access to health insurance for all Americans and a comprehensive set of benefits that emphasizes preventive services and primary services. Our plan calls for everyone to have a personal physician who is a generalist in one of the generalist specialties, such as family practice, general internal medicine, or general pediatrics, and in the Health Care Security Act, OB/GYN, as you know, has recently been added.

Our plan includes specific strategies for moving the physician workforce to a balance of generalists and specialists; approximately 50 percent generalists and 50 percent specialists. It calls for stringent, enforceable cost-containment principles.

Prescription for Health, our plan, as originally written in 1989, has much in common with the Health Security Act, the President's plan, and also has much in common with some of the principles in the major plans before you today. The administration's proposal, we think, provides a positive framework and a good starting point to debate health care reform.

We would like to emphasize that, as deliberations on reform continue, the key elements that we see must not be compromised. Every American must have coverage, universal coverage, which is not the same as universal access, but we are for universal access, as well, and comprehensive benefits. We feel that cost-containment in the health care system can really not be brought under control without universal access and comprehensive insurance reform.

The Academy believes that these goals can best be accomplished by building on the current system of employer-based insurance. Therefore, an employer mandate, applicable to all businesses—yes, including small firms—plays a central role in our reform strategy. We favor this approach for several reasons, and I will enumerate a few of them for you.

First, it builds on the current system that has evolved and is already in place. Most Americans receive their health insurance at their place of employment. Even 62 percent of small business employees receive health insurance at their place of employment. There is probably quite widespread support for an employer man-

date. For example, in the recent poll by the Wall Street Journal and NBC, 65 percent of the public endorsed this principle.

Next, an employer mandate will benefit firms now providing insurance by lifting the burden of cost-shifting. Funds that otherwise would be diverted to health premiums may actually be rechanneled into wages, capital improvement, and other business investment. Particularly, enforcement of universal coverage, to be sure that everyone is covered would be much less cumbersome working through employers.

As attractive as an individual mandate might seem, and actually, in a way, is, it probably would require the development of a whole new bureaucracy to verify insurance coverage and collect premiums for some 240 million people and families, one by one.

Finally, a word about small businesses. As you know, most family physicians practice solo, or two or three doctors, and have about an average of four employees per doctor. We are, then, small businessmen. I serve on the Governor's Task Force on Health Care Reform in the State of Arkansas. We certainly have talked a great deal about the problem of small businesses purchasing health insurance for their employees.

In our State, 90 percent of the workforce are working for small businesses. Health insurance in our State is often not even available today to small businesses. When it is available, it is almost prohibitively costly. Those of you not from Arkansas, I'm sure will not have seen the headlines of the small farm bureau group that has health insurance priced at nearly $10,000 for a family of three. That has been in our headlines in Arkansas for some time now.

So I believe, personally, that the Federal subsidy that is required for small businesses to furnish health insurance has been markedly underestimated. Now, I may be prejudiced because I come from a poor State where most people work for small businesses.

We in the Academy believe that the employer mandate is the option that most likely will guarantee that we achieve universal coverage that will be fully financed, while still maintaining a pluralistic medical system, providing adequate Federal and State subsidy is used to help the small businesses, up front, provide health insurance for their employees, and also some subsidy, we think, will be required in the long run.

The American Academy of Family Physicians looks forward to continuing to work with Congress as you deliberate and decide the most effective strategies for reforming our health care system. I thank you for the opportunity to appear here today, and I would be pleased later to respond to your questions.

Thank you.

[The prepared statement of Dr. James R. Weber follows:]

James R. Weber, M.D.
President-elect

Mr. Chairman, my name is James R. Weber, M.D. I am a family physician from Jacksonville, Arkansas and it is my privilege to serve as the president-elect of the American Academy of Family Physicians. It is on behalf of the Academy's 74,000 members that I express sincere appreciation for the opportunity to appear before the subcommittee and provide you with the Academy's views on health system reform, with particular emphasis on the achievement of universal coverage.

Background

Since the mid-1980s the issue of universal health insurance coverage has been of central importance to the Academy. At that time, the primary impetus for national concern was the growing number of uninsured people and their inability to access appropriate care. Studies documented what family physicians have long known: people who delay seeking medical care have higher morbidity and mortality and are more costly to treat. As the percentage of the gross domestic product spent on health care in this country has escalated, national attention on the problem of access has shifted to an equivalent concern about cost. The American Academy of Family Physicians shares these dual concerns.

Responding to our membership's concerns, in 1989 the Academy became the first physician organization to develop a plan for universal access through a public-private effort, building on the current model of employer-based insurance. In April 1992, the Academy released its revised and expanded plan for health reform, *Rx for Health: The Family Physicians' Access Plan.*

Rx for Health

Rx for Health calls for universal access to a comprehensive set of benefits that emphasize primary and preventive care. The Academy has long-supported an *explicit* comprehensive benefits package. In *Rx for Health*, the Academy defines a basic benefits package that covers virtually all medical services. With the exception of prenatal care, well baby, well child services and childhood immunizations, which require no patient cost-sharing or deductible, access to other services is limited only by a required patient coinsurance and/or deductible. In our view, initially covering medical services will save money in the long term.

The Academy's plan builds upon the present employer-based system and requires all employers, including small businesses, to provide insurance to their employees and dependent family members. Employers pay a specific portion of the premium. Employee cost sharing varies according to income.

Better management of patient care is emphasized in *Rx for Health*. A key element of the Academy's plan calls for each person to have a personal physician in one of the generalist specialties (family practice, general internal medicine or general pediatrics). Increased cost sharing is incurred if an individual seeks non-emergency subspecialty care without referral from the personal physician. *Rx for Health* includes specific strategies for moving toward a physician supply that is balanced between generalists and specialists. Physician workforce goals must reflect the health care needs of the population. Correcting the problems of specialty imbalance in the system will require significant changes in current federal policies and aggressive

interventions. These efforts are controversial as they challenge the status quo, but they are essential if we are to achieve universal access to comprehensive health benefits.

Furthermore, the plan calls for improved quality utilizing practice parameters and malpractice reforms, including caps on non-economic damages. And, to address spiraling health care costs, it includes stringent cost-containment provisions. The Academy strongly supports enforceable health care cost containment though the application of a global budget. We took and continue to adhere to this position because ensuring universal health insurance coverage cannot be achieved without reining-in health care costs. If we are to be serious in our commitment to universal coverage, then we must be absolutely serious in our commitment to contain runaway health care costs. Any proposal to provide universal coverage that does not contain enforceable cost-containment is simply not credible.

In developing *Rx for Health*, we searched for the best mechanisms for achieving real cost-containment. Our strategy, like many other proposals, is multifaceted. We have proposed various administrative simplifications, professional liability reforms, expansions in primary and preventive care, and structural reforms designed to improve the management of patient care.

However, as important as each of these individual reforms might be, we do not believe real cost-containment can be achieved without a mechanism that over-arches the entire health care system. When we looked at other developed countries, it was readily apparent that the only consistently successful mechanism for controlling health care expenditures is global budgeting. It may not

be that global budgeting is the only mechanism that can control costs, but it the only one that we found to have a documented record of success. A national health board is established and has the authority to set and enforce a global budget. Enforcement is targeted specifically to those segments of the health care system responsible for inappropriate spending increases.

Rx for Health is the Academy's vision of health care reform. It has for some time now formed the basis of our discussions with members of the House and the Senate, and with the Administration and other reform advocates. In short, the plan is the gold standard against which we will evaluate all reform proposals, and it includes the specific elements we will seek as you and your colleagues work for enactment this year of comprehensive reform that guarantees universal coverage.

Rx for Health has much in common with President Clinton's plan. Based on our review of the *Health Security Act*, the Academy supports the principles and many of the strategies espoused in the Administration's health reform proposal. The plan provides a positive framework for considering the many complex issues entailed in health system reform and is a good starting point for revision. Academy members are particularly pleased with the commitment of the President to universal access to a set of comprehensive benefits that include preventive services and prescription drugs and that provide a good start on mental health coverage. As deliberations on reform continue, these elements must not be compromised. Everyone in the United States must have access to comprehensive, affordable, high-quality health care services.

As we strive to achieve this mutual goal, the Academy believes we must keep in mind the original catalyst for seeking reform -- the promise of affordable health insurance that includes comprehensive benefits for every individual. In the following statement I will comment at greater length about the role of an employer mandate in realizing this goal.

Consistent with the objective of securing universal coverage that ensures appropriate, affordable health care, the Academy supports a combined private/public sector effort in which an employer mandate plays a central role. We believe that all employers should be required to provide health insurance that offers a comprehensive benefits plan, as defined by the federal government. Workers and their dependents should be covered by the plan. Small businesses are not exempt from the employer mandate under terms of the Academy blueprint. However, the Academy is sensitive to the varied resources of firms of all sizes and, for this reason, believes that the employer's contribution to health plans must be set to ensure a fair balance with the worker's portion of the insurance premium and cost sharing.

As for publicly sponsored coverage, the other half of the equation, the Academy recommends in *Rx for Health* that each state establish a public program to replace Medicaid. This program would contract with private carriers to offer health insurance meeting the same standards required for employer sponsored plans. The state program would be available to small businesses and to individuals not otherwise covered by their employer or government health plans, such as Medicare. Financial assistance for premiums and cost sharing under the public plan would be based on income.

The Academy contends that enactment of these principles will result in an effective. straightforward national health policy under which all persons not otherwise covered today may at last be insured. Moreover. the Academy strongly believes that the adoption of an employer mandate as part of health system reform will help provide every American with genuine health security -- regardless of age, income, employment status or medical condition.

The *Health Security Act* and the Employer Mandate

As introduced, the *Health Security Act* stipulates the establishment of a nationwide employer mandate as the means of achieving universal coverage. Consistent with the principles of *Rx for Health*, the legislation specifies that the payment of insurance premiums will be split between employer and worker, the legislation specifying that 80 percent of the cost is contributed by the employer and 20 percent by the worker. Regardless of size, the contribution made by businesses towards employee health insurance premiums is capped at 7.9 percent of payroll. Firms with less that 75 workers have even lower caps, ranging from 3.5 percent to a maximum of 7.9 percent, depending on their average wage. These smaller businesses are eligible for subsidies to help them purchase health insurance.

As stated above, attaining universal coverage is essential to health system reform and an employer mandate is the mechanism by which the Academy believes we are most likely to reach this goal. Unlike other competing suggestions, the employer mandate has specific strengths that make it a sound option for policy makers to adopt.

First, the employer mandate builds upon the current system. The system of employer-based health insurance became prevalent during World War II. Health insurance was offered and paid for by firms competing to attract and retain workers. After the war, the system continued growing as employer contributions for health insurance premiums became tax deductible, health insurance became a part of collective bargaining negotiations, and insurance companies found that costs for marketing, enrollment, and the collection of premiums were lower for groups than individuals. Today, workers themselves also favor employer-provided insurance because premium payments by employers are exempt from their gross taxable income, essentially raising their effective wage rate.

Right now, a majority of the population (roughly 150 million individuals) -- including 62 percent of small business employees -- get their health insurance through the work place. Strengthening employer responsibility by enactment of an employer mandate will extend this already widespread benefit system to those not now covered by it. Moreover, the idea of an employer mandate to achieve universal coverage is hardly a new one: the health reform plan that former-President Nixon submitted in 1971 also included an employer mandate.

Second, an employer mandate will reduce public expenditures. Today, the cost of treatment for uninsured individuals, including those who are employed, is shifted largely to those firms that provide coverage to their workers. This situation affects the competitiveness and flexibility of commerce and workers alike, contributing to problems such as job lock, industrial inefficiency, and a growing burden upon state and federal treasuries of wholly publicly-funded

health care for poor and near-poor individuals. By contrast, universal coverage under an employer mandate would require smaller public subsidies for the poor and near-poor because it would ensure that the majority of low-income Americans receive their health insurance coverage through the work place rather than through public assistance programs. Alternative options for guaranteeing universal coverage such as broad-based new taxes or draconian, offsetting savings in other health programs are unlikely to attract majority support in the Congress, or among the public. However, a recent *Wall Street Journal/NBC* poll found 65 percent support among the public for the employer mandate approach.

Third, an employer mandate will benefit many employers currently funding plans and who are struggling to meet the escalating cost of health benefits for their workers. Employers who now provide health insurance benefits have been shown to cover more than their fair share of costs. On average, providers charge an extra 25 percent more to the private sector to cover the costs of the uninsured and underinsured. Under reform, this burden would be lifted. However, without reform, employers that now offer health benefits would see their premiums rise approximately 70 percent by the year 2000. But with enactment and implementation of reform that includes an employer mandate, such as the one in the *Health Security Act*, these premiums are expected to rise 29 percent -- less than half as much as under the status quo. In business terms this means that firms would divert about 8.2 percent of payroll to employee health benefits in the year 2000 without reform, but that this amount would drop to roughly 6.6 percent if Congress approves a reform law that includes the employer mandate. For family physicians, like other employers, this welcome relief means that businesses would at last be able

to re-channel these funds that otherwise would have been spent on health care to wages, investment in new machinery and technology, and other quality improvement and competitive applications.

In the President's plan, as with *Rx for Health*, the employer mandate will benefit the majority of employers currently offering health insurance to their workers in the following ways:

- Caps on employer premiums as a percentage of payroll will create new limits on the exposure of all employers to increases in health care costs. Firms now struggling to balance skyrocketing health care costs with the need for capital and other productivity enhancements will get some overdue relief.

- Subsidies will, for the first time, be available to support small businesses in meeting the costs of health insurance.

- Employee cost sharing requirements will induce price sensitivity among consumers. Individuals will pay more if they choose more expensive health insurance coverage.

Finally, an employer mandate eases enforcement in a system of universal coverage. Premium collection and payment under an employer mandate will continue to be automatically deducted by employers from workers' paychecks, thereby building on the existing system.

However, an individual mandate may require the Internal Revenue Service or some other entity (or combination of government entities) to verify the health insurance coverage of more than 240 million individuals. Achieving universal coverage will require some mechanism for enforcement that, in our view, is more easily implemented through employers than by monitoring each citizen separately.

A Word About Small Businesses

Family physicians typically practice solo or in small group arrangements. As small business owners and employees, we are very concerned about the potential for adverse economic consequences resulting from system-wide health reform. As stated earlier, that is why *Rx for Health* stipulates small businesses should be eligible to purchase health insurance from a state-established public program with the amount of the employer's contribution based on a reasonable percentage of payroll. This approach is similar to the one posited as part of the *Health Security Act*. As mentioned previously, a majority of the population (roughly 150 million individuals) -- including 62 percent of small business workers -- obtain their health insurance through their work place. The Academy believes that small employers now offering insurance or wishing to (including many family physicians), will benefit from health reform that includes an employer mandate.

It should be noted the Administration found that employers with less than 25 workers would by the year 2000 spend approximately 9 percent of payroll on health benefits in the absence of

reform utilizing an employer mandate. With a mandate, however, it is projected that these same employers would spend only 6.4 percent of payroll for health benefits. As mentioned earlier, the *Health Security Act* also caps employer spending on health insurance at 7.9 percent of payroll regardless of the size of the firm. Businesses with less than 75 workers have even lower caps under the legislation, ranging from 3.5 percent of payroll to the full 7.9 percent, depending on their average wage level.

Although *Rx for Health* does not include specific recommendations regarding payroll caps, premium cost sharing levels or subsidy amounts, the plan explicitly backs the principle of fairness and sufficiency in the design and implementation of the employer mandate as it relates to all businesses -- and with a special sensitivity to the needs of small businesses. Accordingly, the Academy is eager to work with you and your colleagues to determine the appropriate payroll caps, subsidy amounts and cost sharing levels needed to make an employer mandate acceptable to the public and a workable component of universal coverage.

Conclusion

I deeply appreciate the opportunity to comment today health system reform on behalf of the American Academy of Family Physicians. Our organization is committed to work for enactment of comprehensive health system reform, ensuring universal coverage, providing a comprehensive set of benefits, achieving enforceable cost containment, rebuilding the nation's primary care infrastructure. In our view the issue of the employer mandate is the keystone upon which hangs

the remaining structure of a reformed, comprehensive health delivery system. Without an employer mandate it is unlikely that universal coverage and genuine health reform will be achievable while still maintaining our pluralistic system. To this end, the American Academy of Family Physicians is looking forward to working with you to attain the positive changes that we all seek. I would be pleased to answer any questions you may have at this time.

Chairman WILLIAMS. Thank you very much.

Our next witness is Dr. David Murray from New York, who is chairman of the Board of Regents of the American College of Surgeons.

Thank you for being with us, Doctor.

STATEMENT OF DR. DAVID G. MURRAY, SYRACUSE, NEW YORK, CHAIRMAN, BOARD OF REGENTS, AMERICAN COLLEGE OF SURGEONS

Dr. MURRAY. Mr. Chairman and members of the subcommittee, I come to you not only as chairman of the Board of Regents of the American College of Surgeons but also as a practicing orthopedic surgeon in Syracuse, New York.

I am very pleased to have this opportunity to offer some comments on some aspects of health system reform, in particular the President's Health Security Act, that are of concern to surgeons. The College certainly commends the President for his leadership in proposing steps to bring about reforms to the Nation's health care system. We heartily support his call for achieving universal access to health care. Nevertheless, there are several aspects of the President's plan that are of significant concern to us.

For example, the plan calls for a major restructuring of the health care system through the creation of a new and highly bureaucratic scheme. All sorts of new boards, corporations, advisory councils, and other quasi-governmental alliances would be created throughout the country to carry out a variety of activities at a time when we should be streamlining our system and reducing bureaucratic and overhead burdens which drain funds that could be used to provide health care services.

We do applaud the features in the President's plan that would provide Americans a choice of at least three different types of health plans, including a fee-for-service plan. The College is very apprehensive, however, about the extensive powers granted to the alliances under the President's bill. It is imperative that the fee schedules developed by the alliances or by the States be established in a reasonable and fair manner, if a fee-for-service enrollment option is to be viable one.

For example, if fees are set at unreasonably low levels, as they have been in many States under Medicaid, then real opportunities for individuals and families to enroll in plans where patients can see the physician of their choice may end up existing in name only.

In addition, we believe Congress should consider certain criteria that alliances and States would have to meet in setting fee schedules. They should be required to take into account and publish an assessment of, one, the adequacy of payments to assure access by plan enrollees to the full range of covered services; two, the willingness of providers to accept patients under the terms of the fee schedule; and, three, the number of consumers enrolled in fee-for-service plans or plans that permit them to obtain services from out-of-plan providers.

In addition, there should be a requirement that no alliance or State fee schedule amount for a particular service may be less than the amount payable for that same service under the Medicare program. Moreover, if spending targets are adopted as part of any pro-

spective budget process, we believe that a separate expenditure target for surgical services should be established.

Frankly, Mr. Chairman and members of the subcommittee, the regents of the American College of Surgeons are of the view that the single-payer approaches to health reform probably provide the best assurances, the most consistent and the most effective methods whereby patients would be able to continue to seek care from high-quality physicians of their choice.

The College is troubled by the President's proposed global budgeting scheme to cap insurance premiums. We are especially concerned about the administration's plan to severely ratchet down the rates of increase in health care spending from current levels in a very short period of time. We do not see how such a dramatic reduction in the rate of increase in spending levels can be achieved without the potential for serious disruption or damage to the Nation's health care infrastructure, particularly at a time when other aspects of the President's reform program would substantially increase public demand for health services through new and greatly expanded coverage for millions of Americans.

Finally, the College believes that Congress should consider graduate medical education financing and the physician workforce issues in conjunction with any long-range health reform plan. However, we are troubled by a provision in the President's plan that would require the Secretary of Health and Human Services to appoint 10 regional councils to allocate training slots among individual residency programs.

Instead, the College believes that the existing structure of the residency review committees should be given the responsibility for establishing the program criteria that would work best to implement any national physician supply targets.

Again, the College is pleased to have this opportunity to share some of its thoughts on the health system reform issues, and I would be pleased to answer any questions that you might have.

Thank you.

[The prepared statement of Dr. David G. Murray follows:]

STATEMENT

of the

AMERICAN COLLEGE OF SURGEONS

to the

Subcommittee on Labor-Management Relations

of the

House Committee on Education and Labor

presented by

David G. Murray, MD, FACS

RE: Health System Reform

February 10, 1994

Mr. Chairman and members of the subcommittee, I am David G. Murray, MD, FACS, Chairman of the American College of Surgeons' Board of Regents and a practicing orthopaedic surgeon from Syracuse, New York. On behalf of the more than 60,000 Fellows of the College, I am pleased to have this opportunity to offer comments on some aspects of health system reform -- and the President's Health Security Act, in particular -- that are of concern to surgeons.

The College certainly commends the President for his leadership in proposing steps to bring about reforms to the nation's health care system. We support his call for achieving universal access to health care and for making needed reforms in the insurance marketplace. We also welcome his interest in medical liability reform and administrative simplification, which, in our view, are long overdue. Nevertheless, there are several aspects of the

President's plan that are of significant concern to us.

Reorganizing the Health Care System. The President's plan calls for a major restructuring of the health care system through the creation of a new and highly bureaucratic scheme. All sorts of new boards, corporations, advisory councils, and other quasi-governmental alliances would be created throughout the country, to carry out activities such as: setting and enforcing global budgets; implementing regulations governing the content of health plans; negotiating fees; managing the post-graduate training of physicians; collecting and disseminating vast amounts of data on health care services and financing; reviewing quality of care; collecting premiums, and so on.

At a time when we should be streamlining our system and reducing bureaucratic and overhead burdens which drain funds that could be used to provide health care services, we find this very disturbing and fraught with the potential of seriously undermining the public's expectations about our ability to proceed along the path to reform.

We realize that health system reform will also require that new financial resources be invested to achieve the goals of universal access and coverage. However, the College believes the Administration has unrealistic expectations about financing the reform effort through deep reductions in the Medicare and Medicaid programs, largely through significantly decreased payments to those who now provide health care services to elderly, disabled, and low-income Americans.

Patient Choice. We do applaud the features in the President's plan that would provide Americans with a choice of at least three different types of health plans, including plans that will allow participants the option of consulting any health care provider, subject to reasonable plan requirements. Indeed, the College supports the continuing ability of individuals and families to meet their health care needs through a variety of arrangements, and we would be very concerned if the President's plan failed to provide realistic opportunities for enrolling in plans that make it possible to obtain services from any physicians or surgeons of their choice.

Under President Clinton's health reform plan, individuals and families would have an opportunity to enroll in different types of health benefits plans, including a fee-for-service (FFS) plan. Services provided to those enrolled in the FFS plans would be reimbursed according to a single fee schedule that would be established by each regional alliance. This single fee schedule would also apply to services furnished under the FFS component of an alliance health plan. A state could adopt its own statewide fee schedule for such purposes, instead of using alliance specific schedules. Alliances or states may also use prospective budgeting to create fee schedules that contain spending targets for each sector of health spending.

The College is very apprehensive about the extensive powers granted to the alliances under the President's bill. But, should these entities be given the responsibilities outlined in the Administration's plan, it is imperative that the fee schedules developed by the

alliances, or by the states, be established in reasonable and fair manner if a FFS enrollment option is to be a viable one. For example, if fees are set at unreasonably low levels, as they have been by many states under Medicaid, then real opportunities for individuals and families to enroll in plans where patients can see any physician of their choice may end up existing in name only.

The College notes with considerable interest that, under the President's plan, providers would be allowed to negotiate collectively with the regional alliances, or with states, for the purpose of establishing the single fee schedules. Providers could collectively and jointly meet, confer, consult, and so on, to develop information needed to negotiate the elements of the fee schedule. We think that more details must be provided, however, before we can assess how such a process of negotiations would actually work and how the concerns of different kinds of health care providers, including surgeons, would be addressed.

We believe Congress should consider certain criteria that alliances and states would have to meet in setting fee schedules. For example, the alliances and states should be required to publish not only their payment schedules, but also information on how they arrived at the respective payment amounts. In addition, guidance should be provided to identify the kinds of factors that states and alliances should consider in order to arrive at fair and reasonable payments for services. Alliances and states should also be required to take into account and publish an assessment of: (1) the adequacy of payments to assure access by plan enrollees to the full range of covered services; (2) the willingness of providers

to accept patients under the terms of the fee schedule; (3) the number of consumers enrolled in FFS plans or plans that permit them to obtain services from out-of-plan providers; and (4) a comparison of the fee schedule amounts for physician services in the area with payment levels under fee schedules negotiated by other alliances or states. In addition, there should be a requirement that no alliance or state fee schedule amount for a particular service may be less than the amount payable in the area for that same service under the Medicare program. Moreover, if spending targets are adopted as part of any prospective budget process, we believe that a separate expenditure target for surgical services should be established.

Budgetary Controls and Spending Targets. The College is troubled by the President's proposed global budgeting scheme to cap insurance premiums, which, in our view, concentrates far too much regulatory authority in the hands of government and alliance officials. As we understand it, the federal government would be responsible for enforcing controls over health spending--at least in the private sector--through rate of increase limits on the weighted average premiums established for each alliance in the United States. If the average weighted bid for an alliance is greater than the regional alliance per capita premium target set by the National Health Board, the Board could order that the premium bids of some plans be reduced. These reductions, in turn, would be passed along to providers participating in the affected plans.

We are especially concerned about the Administration's plan to severely "ratchet

down" the rates of increase in health care spending from current levels in a very short period of time. Under the President's plan, a national per capita premium target and a general health care inflation factor would be used by the National Health Board to determine regional alliance-specific per capita premium targets, taking into account variations in demographics and certain other characteristics of the population covered in each alliance. Eventually, however, the only inflation factor recognized would be changes in the consumer price index (CPI), until Congress considers recommendations from the Board for making premium adjustments due to inflation in the years after 1999.

We do not see how such a dramatic reduction in the rate of increase in spending levels can be achieved without the potential for serious disruption or damage to the nation's health care infrastructure, particularly at a time when other aspects of the President's reform program would substantially increase public demand for health services through new and greatly expanded coverage for millions of Americans.

Moreover, establishing spending targets on the basis of price level changes in the general economy and changes in demographics alone seems rather short-sighted. There are, for instance, many factors that may drive the demand for health services--nationally and in particular locales--over which those who provide such services have no control. How, for example, would the rapidly growing AIDS epidemic be taken into account in assigning allowable premium rate increases in areas that are now experiencing the most devastating and costly effects of treating this deadly disease? Likewise, many of our most advanced and

skilled health care resources are concentrated in special centers of excellence and are not distributed evenly across the country. Their expenditure experience may be difficult to account for, if only price and population are used to allow for spending growth in those areas.

Physician Workforce/Graduate Medical Education. Finally, the College believes that Congress should consider graduate medical education financing and physician workforce issues in conjunction with any long-range health reform plan. We think it is reasonable to consider reducing the total number of residency positions currently available, and to reconsider the rationale for maintaining such a large number of post-graduate positions that are now filled by international medical graduates. The College believes that establishing specific numerical limits on the number of physicians to be trained may be an effective way for policymakers to determine the future mix and numbers of medical and surgical specialists. In general, the President's reform plan proposes to manage the number of post-graduate training positions and to provide funding directly to the training programs.

However, we are troubled by a provision in the President's plan that would require the Secretary of Health and Human Services to appoint 10 regional councils to allocate training slots among individual residency programs. These government-controlled councils would consist not only of representatives of academic institutions that train physicians in these regions, but also representatives of regional health alliances, health plans, consumers, and others.

Instead, the College believes that, if the Secretary establishes national residency goals after obtaining any advice she feels necessary, the existing structure of the Residency Review Committees should be given the responsibility for establishing the program criteria that would work best to implement the national physician supply targets. We also believe that the President's proposals for graduate medical education financing should explicitly include a policy of adequate government funding for all residencies through the entire course of the training period. If we commit ourselves to establishing the number of physicians we want to train, it seems only reasonable to support that training for the full residency period.

Again, the College is pleased to have this opportunity to share some of its thoughts on the health system reform issues, and I would be pleased to answer any questions you may have.

Chairman WILLIAMS. Thank you, Doctor.

The next witness is a member of the Board of Directors of the American Nurses Association, Ms. Gwendylon Johnson, who is an RN, I believe.

Ms. JOHNSON. Yes.

Chairman WILLIAMS. Thank you for being here.

Ms. JOHNSON. Thank you.

STATEMENT OF GWENDYLON E. JOHNSON, RN, MEMBER OF THE BOARD OF DIRECTORS OF THE AMERICAN NURSES ASSOCIATION, WASHINGTON, DC

Ms. JOHNSON. Good morning, Mr. Chairman and members of the committee.

I am Gwendylon Johnson, a member of the board of the American Nurses Association. I also appear here today on behalf of the American Association of Critical Care Nurses, the American Association of Colleges of Nursing, the National Nurse Practitioner Coalition, and the American Association of Spinal Cord Injury Nurses.

We commend the committee for providing a forum to begin to address the implications of health care reform on those who provide care. The health care industry is the Nation's third largest employer, accounts for one-seventh of the Nation's economy, and has been the largest creator of new jobs since 1980. Clearly, major shifts affecting this industry will have great implications for our Nation.

Nurses are patient advocates. Thus, we look forward to the implementation of an inclusive, effective health care system. We know firsthand of the inequities and problems within our current delivery model. We know all too well that the system succeeds for some yet fails for too many others.

Nurses have always been the backbone of our Nation's health care system, providing around-the-clock care, seven days a week. Nurses are the single largest group of health care providers. Registered nurses practice wherever people need nursing care; however, the majority of nurses work in hospitals, the arena in which the most dramatic changes are taking place.

As you continue your deliberations on health care reform, we urge the committee to consider the implications of the following workplace issues:

First, changes in demand for health care under the Health Security Act will require an adequate supply of appropriately educated health care providers. Health care reform efforts must be accompanied by education of new health care professionals, as well as adequate retraining and redeployment of the current health care workforce, if consumers are to fully benefit from a reform system. This should include retraining and dislocated worker services, as well.

Second, advanced practice nurses are well positioned to fill the gaps in accessibility of primary and preventive care services. Advanced practice nurses, including nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists are trained to provide from 80 to 90 percent of the necessary primary care services of our Nation. A dedicated funding

stream for graduate nursing students is necessary to prepare for the increased need for advanced practice nurses.

Health care reform will accelerate the shift to a community-based system of care, which may result in significant redeployment of the current nurse workforce. We support the Health Security Act provisions designed to address workforce issues. Different levels of training and education, from skill enhancement to additional academic education, will be required for some nurses to transfer hospital skills to other settings.

Funding must be made available to support the education and training of these nurses.

Over the past year, ANA has tracked a growing number of reports about changes in workforce patterns in the health care industry. There are frequent reports of changes in skill mix, abrupt and unannounced layoffs, and increasing use of unlicensed, lesser qualified personnel to do work previously done by RNs. We believe these are shortsighted actions which could have negative consequences. Layoffs are occurring in an environment in which patients are sicker and hospital stays are shorter.

The layoffs of nurses points to the need for improved employee protections. ANA believes that any hospital's decision to significantly alter staffing levels or professional mix should include advanced public disclosure of plans and educational programs for professionals. We are pressing for a national health care reform transition plan to assure that reform can be carried out without premature hospital closures, massive dislocation of employees, and threats to the quality of patient care services.

All nurses must have access to programs and benefits designed to assist dislocated workers. The dislocated workers initiatives which the President will send to this committee in the coming weeks must be designed so as not to exclude those nurses who currently work part-time. We are pleased to see support services, such as child care, included as an appropriate expenditure of funds in the administration's drafts.

As health care reform reshapes our future and our health care delivery system, it will be essential to ensure an adequate supply of advanced practice nurses to meet the increased demand for primary care services. We support the provisions in the Health Security Act for a dedicated funding stream for graduate nurse education. This bill would provide a revenue source that is not subject to the annual appropriations process, to expand the current production of advanced practice nurses.

Education programs alone, however, will not solve the problem. The ability of nurses to provide health care has been hampered by artificial barriers that limit access to services provided by these competent and qualified health providers. Laws, regulations, and practice provisions governing reimbursement for advanced practice nurses are so confusing and complex that they, in themselves, have become a barrier to access to these services.

Mr. Chairman, we support reform that provides universal access to care and balances the need to contain costs with the need to provide quality health services. Hospitals that are concerned only about saving may find employees concerned only about saving jobs. Neither is the right approach. We endorse the use of the most ap-

propriate provider to meet the consumer's health care needs in every setting. The success of health care reform will depend, in part, on matching the right provider to the right need.

Thank you very much.

[The prepared statement of Gwendylon Johnson follows:]

GWENDYLON JOHNSON, RN
BOARD OF DIRECTORS
AMERICAN NURSES ASSOCIATION

Good morning Mr. Chairman, members of the Committee, I am Gwendylon Johnson, RN member of the Board of Directors of the American Nurses Association (ANA). The American Nurses Association is the professional organization representing the nation's two million registered nurses (RNs) through 53 state and territorial nurses associations. ANA is also a labor organization, representing, through state nurses associations, more registered nurses in collective bargaining than all other unions combined. I appear today on behalf of the American Association of Critical-Care Nurses (AACN), American Association of Colleges of Nurses, American Association of Spinal Cord Injury Nurses and the National Nurse Practitioner Coalition (NNPC).

I appreciate the opportunity to testify today before the House Subcommittee on Labor-Management Relations on the Workforce Implications of Health Care Reform. We commend this Committee for providing a forum to begin to address the implications of health care reform on those who provide care. As you know, the health care industry is the nation's third largest employer, accounts for one-seventh of the nation's economy, and has been the largest creator of new jobs since 1980. Clearly, major shifts affecting this industry will have great implications for our nation.

We believe this Committee is uniquely positioned to address proactively the workforce needs of a new health care system. To move ahead with health care reform without anticipating the impact it will have on the current industry workforce would be like

writing only the first act of a two-act play. We can't afford to wait until a new health care structure is set up to find out whether we have the qualified persons to deliver promised services. We commend you for seeking answers to one of the most critical questions in health care reform: Will the skills of the nation's health care workers match the needs of the system?

Nurses are first and foremost patient advocates, thus, we look forward to the implementation of an inclusive, effective health care system. We know firsthand of the inequities and problems within our current delivery model. We know all too well that the system succeeds masterfully for some, yet fails shamefully for too many others. Professional nurses have always been the backbone of our nation's health care system--providing around the clock care seven days a week as both illness and wellness professionals. Nurses are the single largest group of health care providers. Registered nurses practice wherever people need nursing care--hospitals, nursing homes, schools, home health agencies, the workplace, community health clinics, in private practice and in managed care settings. The majority of nurses (two out of three) work in hospitals -- the arena in which the most dramatic changes are taking place.

As you continue your deliberations on health care reform, we urge the Committee to consider the implications of the following workplace issues:

1. Changes in demand for health care under the Health Security Act will require an adequate supply of appropriately educated health care providers. Health care reform efforts must be accompanied by adequate retraining and redeployment of the current professional health care workforce if consumers are to fully benefit from a reformed system. This will include training and dislocated worker services.

2. Advanced practice nurses are well-positioned to fill the gaps in accessibility of primary and preventative care services. Advanced practice nurses, including nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists, are trained to provide from 80-90 percent of the necessary primary care services of the nation. A dedicated funding stream for graduate nursing students is necessary to prepare for the increased need for advanced practice nurses.

3. Hospital efforts to restructure and contain costs must be handled responsibly. Downsizing with increased reliance on unlicensed aides, without a full assessment of the impact on patient care, may seriously jeopardize patient safety and access to quality services. Congress should enact interim quality protectors to safeguard patient care during this period of transition.

RETRAINING, REDEPLOYMENT AND EDUCATION OF THE WORKFORCE

Health care reform will accelerate the shift to a community-based system of care which will result in redeployment of the current nurse workforce. States will need to respond to the development of health alliance plans and the concomitant evolution of new jobs in primary, preventive, critical and community care arenas. We support the provisions in the Health Security Act designed to address these workforce issues. We support the development of the National Institute for Health Care Workforce Development. We believe that a body to analyze the workforce needs of a new health care system will be critical during this time of transition. The Institute would be made up of representatives from health care institutions, labor unions, educators, and consumers--all of whom have a stake in creating a health care system that works.

Different levels of training and education, from skill enhancement to additional academic education will be required for some nurses to transfer hospital skills to other settings. These are considerations for many acute and long term care nurses who will most likely not be adequately prepared to work in these settings. Funding must be made available to support the education and training of these nurses.

All nurses must have access to dislocated worker programs and benefits designed to assist dislocated workers. The dislocated worker initiatives which the President will send to this Committee in the coming weeks must be designed so as not to exclude those nurses who currently work part-time. Approximately one third of nurses work part-time. These nurses

may be attending school or caring for their young children, but their income is critical to the support of their families. We are pleased to see support services, such as child care, included as an appropriate expenditure of funds in the Health Security Act and in drafts of dislocated worker legislation.

The escalating layoffs of nurses resulting from hospital mergers and closures point to the need for improved employee protections. We believe that any hospital's decision to significantly alter staffing levels or professional mix or to redeploy personnel should include: 1) advanced public disclosure of plans to merge, close, or significantly layoff personnel; and educational programs for professionals to prepare them for redeployment. We are pressing for a national health care reform transition plan to ensure that reform can be carried out without premature, reactive hospital closures, massive dislocation of employees, and serious threats to the quality of patient services.

We will continue to work with Congress, the Departments of Labor (DOL) and Health and Human Services (HHS) to ensure that retraining efforts focus on increasing the future workforce of professional providers and not unintentionally create a large pool of low-skilled health care providers.

The Health Security Act is currently the only health care reform proposal before Congress which addresses the education and retraining needs of nurses. We believe these

provisions to be critically important and should be included in any health care reform proposal which passes Congress.

GRADUATE NURSING EDUCATION

We are pleased to see that the Health Security Act includes a proposal for a dedicated stream of funding for advanced practice nurses. As health care reform reshapes our health care delivery systems, it will be essential to ensure that there is an adequate supply of advanced practice nurses to meet the needs of universal coverage.

The expanded role of nurses in a reformed health care delivery system, including advanced practice nurses such as nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists, is critical to ensuring access as well as delivery of needed health care services to all populations, including the underserved. An important element of most health care reform proposals currently pending before Congress is the emphasis on preventive and primary health care services. These very services have been at the center of nursing practice since the inception of the profession. Nurses are the key providers in acute care, as well as school and community health clinics, home care, hospice care, and ambulatory care, all services which are part of the package of benefits under President Clinton's *Health Security Act*.

Nurses are well-positioned to fill many of the current gaps in accessibility and availability of primary and preventive health care services. Advanced practice nurses are

trained to provide from 80 to 90 percent of the necessary primary care services of the nation. Primary care services include: preventive care and screening, physical examinations, health histories, basic diagnostic testing, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, care of minor injuries, education and counseling on health and nutrition issues, minor surgery or assisting at surgery, prenatal care and delivery of normal pregnancies, well-baby care, continuing care and management of chronic conditions, and referral to and coordination with specialty caregivers. Of the 2.2 million registered nurses in the United States, about 100,000 are considered advanced practice nurses with advanced education and training in providing primary care. This training includes an advanced certificate or degree beyond the four-year Bachelor of Science degree. Of the total advanced practice nurses currently in the workforce, about one-half are engaged in primary care.

Today, there are approximately 25,000 nurses practitioners practicing - most of whom are engaged in the delivery of primary care services. Most of the 150 nurse practitioner programs in the United States grant a Master's degree. Nurse practitioners can write prescriptions in 35 states.

Most of the 40,000 clinical nurse specialists currently practicing are in the areas of cardiology, mental health, cancer care or neonatology. Other clinical nurse specialists are case managers in the care of chronic health conditions such as diabetes, or health and nutrition educators and work in a primary care health setting. Clinical nurses specialists

have often earned their Master's or Doctoral degrees in their specialty areas of practice. As the hospital workforce shifts to a lesser dependency on medical residents, hospital administrators are depending on the use of advanced practice nurses such as nurse practitioners and clinical nurse specialists to provide many of the responsibilities once undertaken by the medical residents. This workforce is critical to the continuing acute care operations of many hospitals.

In addition to the above advanced practice nurses, there are certified nurse midwives who are engaged in prenatal and gynecological care as well as the delivery of babies. Most certified nurse midwives receive 12 to 18 months advanced training above their basic education. Certified registered nurse anesthetists receive a graduate education approximating 27 months of which the first nine months are spent in the classroom with the remaining 16 months spent in clinical training.

To extend coverage to the 37 million Americans currently uninsured will increase the demand for primary care services beyond the level it is expected to grow under the current health care system. Programs are needed, however to provide the education and training necessary to prepare these nurses. President Clinton's *Health Security Act* includes such a provision which proposes a stable dedicated funding stream for graduate nurse education. This funding would provide a revenue source that is not subject to the annual appropriations process to expand the current production of advanced practice nurses.

In November 1993, representatives of major nursing organizations agreed on a set of criteria that we believe should guide the formation of a graduate nursing education program. The criteria are as follows:

♦ The funding focus should be on educational support for advanced practice nursing students;

♦ Graduate Nurse Education funds should not be used to support undergraduate nursing education;

♦ The Graduate Nurse Education fund should have a dedicated funding stream to provide monies in addition to the currently available nursing and allied health funds under the graduate medical education program which is used largely to support nursing diploma programs;

♦ Funding through a Graduate Nurse Education must be in addition to current authorizations under Title VII and Title VIII of the Public Health Service Act.

♦ Students enrolled in the Graduate Nurse Education program should be post-baccalaureate, advanced practice nursing students enrolled in a program that is linked to an academic institution;

♦ All providers (all clinical sites including nursing centers, hospitals, ambulatory care settings, home health agencies, etc.) that incur costs for support of advanced practice nursing education will have access to the Graduate Nurse Education monies for student stipends, costs of clinical nursing faculty supervision at the clinical sites, and program expenses including salaries of support staff. The provider must have a written agreement with an academic institution; and

♦ Classroom costs incurred by rural and urban underserved providers that have agreements with academic institutions should be reimbursed.

The Graduate Nurse Education program would help many graduate nursing students who are currently attending school part-time due to financial constraints become full-time students. The current cost of attaining a nurse practitioner education is similar to students pursuing master's degrees in other areas of study. The American Association of Colleges of Nursing found that based on 1988 dollars, its costs a graduate nursing student about $36,837 without financial aid to receive a Master's degree.

A large portion of a graduate nursing student's programs is in clinical practice. Some certifying exams require the graduate to spend one-third of his or her advanced nurse education experience in the classroom and two-thirds in clinical practice, although in most all cases, the classroom and clinical studies are integrated throughout the graduate student's

curriculum. In other words, even as the advanced practice nurses are training for their degrees, their services are utilized in providing much needed health services.

Study after study demonstrates that advanced practice nurses are an essential means to providing health care services in a cost efficient manner and to underserved populations. Preliminary data from a study being conducted at the University of Wisconsin under a Robert Wood Johnson grant show that when nurse practitioners are utilized by HMOs, the need for physicians decreases from 30 to 50 percent. The data also show that the inclusion of nurse practitioners on the patient care team doubles the efficiency of that team. Another recent survey (*Survey of Beneficiaries of Nursing Education Projects*, December 1993) found that 90 percent of nurse practitioner and certified nurse midwife graduates are engaged in direct patient care. Of those nurses surveyed, more than 60 percent provide maternal and child health care; 25 percent are involved with caring for the homeless; 40 percent provide care to the elderly; and 28 percent care for HIV infected individuals.

Education programs for advanced practice nurses alone, however, will not solve nursing's ability to provide full primary and preventive health care services. The ability of nurses to provide health care services has been continually hampered by a number of artificial barriers that serve to cut the consumer off from access to services provided by these competent and qualified health providers. Factors such as artificially depressed wages, lack of third party reimbursement policies by Federal and state programs and private insurers (particularly through Medicare), limitations of State nurse practice acts, the unavailability of

malpractice insurance and institutional opposition to independent nursing practice have had a major negative impact on the ability of advanced practice nurses to fully practice within their educational and training parameters. The laws regarding reimbursement for advanced practice nurses, for example, are complicated and convoluted as to which categories of advanced practice nurses may be reimbursed, in what geographic areas, who may be paid and whether or not collaboration with other health providers is required. The current laws are so confusing and complex for carriers, providers, and consumers that they have become a barrier to access to these services in and of themselves.

The Health Security Act only goes part way in guaranteeing that barriers to health care for the nation's elderly are removed. Under current law (Public Law 101-508), nurse practitioners and clinical nurse specialists who practice in rural areas are eligible to receive direct reimbursement under Medicare. *The Health Security Act* expands this provision by allowing reimbursement for all nurse practitioners and clinical nurse specialists, regardless of the geographic settings, but inhibits the practice of some advanced practice nurses by setting artificial barriers on the practice setting and the association of the advanced practice nurse with another health care provider. Under *The Health Security Act*, Medicare reimbursement would not be allowed for nurse practitioners and clinical nurse specialists for in-hospital settings and all advanced practice nurses would have to demonstrate collaboration with a physician to be eligible for any Medicare reimbursement. ANA contends that continuing these restrictions will significantly hamper advanced practice nurses ability to provide their services to the elderly. Legislation is currently pending (H.R. 2386) in the House of

Representatives that would remove all arbitrary restrictions from Medicare reimbursement for advanced practice nurses and better serve the needs of the nation's elderly. In addition, this legislation would extend the bonus payment to advanced practice nurses modeled after the current program of bonus payments to physicians who work in health professional shortage areas. Extending bonus payments to non-physician providers has also been recommended by the Physician Payment Review Commission.

PROTECTING PATIENTS FROM UNSAFE CARE

We are concerned that the quality of care may be adversely affected by hospital cost savings strategies. Most hospitals are not waiting for health care reform to occur, but are rapidly making adjustments aimed at lowering their cost structures, joining and forming systems of care to achieve economies of scale, and engaging in various initiatives to ensure greater financial stability. While these may be a necessary part of the transition to a future reformed health care system, we are concerned about the potential for deterioration in the quality of health care.

Over the past year, ANA has tracked a growing number of reports about changes in workforce patterns in the health care industry. There are increasingly frequent reports about changes in skill mix, abrupt and unannounced layoffs, increasing use of unlicensed, lesser qualified personnel to do work previously done by RNs, and hospital restructuring aimed primarily at saving money. We believe these are short-sighted actions that could have immediate consequences. Displacement of registered nurses is occurring as hospitals and

health care facilities respond to the increased prevalence of managed care in the insurance industry and as hospital services shift to outpatient and community settings.

Layoffs are occurring at a time when the length of hospital stay has decreased, census is down but the acuity of hospitalized patients has increased. It is indeed a disturbing trend: the qualifications and skill levels of hospital staff are decreasing in an environment in which patients are sicker and hospital stays are shorter. The nurses who remain are under more stress with increased workloads. Unlicensed assistants are performing tasks that they are not trained to do. For example, it's one thing to delegate assistance with daily living tasks to unlicensed aides, but it's dangerous for a non-RN to monitor the vital signs of a patient fresh out of surgery. While this saves money, it poses risks to patients.

We know from well-documented research that there is a proven relationship between the level of staffing, richness of skill mix and patient outcomes. Patients and doctors make decisions concerning which facility to use based on several factors including quality of nursing care and supervision. A higher proportion of RNs (skill-mix) is directly linked to quality patient outcomes including fewer patient deaths. In addition to morbidity and mortality, nursing care is linked to fewer complications, shorter lengths of stay and fewer patient days; hospital readmission within thirty days; patient falls; medication errors; use of restraints; and incidence of nosocomial infections, etc. Subjective measures such as patient satisfaction and quality of life are also affected. Happier patients are more compliant with treatments. Attached to this testimony is an article by Patricia Prescott, a University of

Maryland researcher, which discusses these issues in greater detail. We request that this article be included in the record of this hearing.

ANA has had several meetings with key White House domestic policy staff and Departments of Labor and Health and Human Services officials regarding the importance of protecting patient care between passage and implementation of health care reform. We believe that Congress must enact certain interim quality protectors to safeguard patients during this transition to a reformed health care system. Such safeguards must be implemented immediately as well as being included as part of a health care reform package. Such measures are essential in order to protect patients from a significant and dangerous downgrading of nursing care in hospitals and nursing homes because of short-sighted elimination of RN positions. Institutions that markedly drop or change staffing in direct patient care areas should be required to account for these changes to the Health Care Financing Administration (HCFA). Hospitals also should be required to document their staffing plans and report to consumers, certifying bodies and regulatory agencies the impact of redeployment on patient outcomes and quality of care. Failure to comply with these requirements should give rise to a presumption that the hospital is delivering unsafe care in violation of Medicare requirements.

CONCLUSION

Mr. Chairman, we support health care reform that provides universal access to care, and balances the need to contain costs with the need to provide quality health services.

Hospitals that are concerned only about saving money may find employees concerned only about saving jobs. Neither is the right approach. We have always endorsed the use of the most appropriate provider to meet the consumer's health care needs in every setting. Whether it is in primary health care services - which can be safely and appropriately delivered by qualified nurses - or acute care hospital and critical care services which require the experienced judgment of a registered nurse, the success of health care reform will depend in part on matching the right provider to the need of the consumer. We applaud this Committee for your strong commitment to developing a health care system that provides access to quality, affordable health care. As your deliberations proceed, we urge you to continue to address the education and training needs of the health care workforce and to take steps to protect the quality of patient care. The system cannot succeed without skilled nurse providers.

We appreciate this opportunity to share our views with you and look forward to continuing to work with you as comprehensive health care reform legislation is developed. Thank you.

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Chairman WILLIAMS. Thank you, Ms. Johnson.
Dr. Richman is from California.
Doctor, thank you for accepting the invitation to be here.

STATEMENT OF DR. KEITH S. RICHMAN, MPH, PRESIDENT AND CEO, MEDCO ASSOCIATES, INC., PACOIMA, CALIFORNIA

Dr. RICHMAN. Thank you, Mr. Chairman and members of the subcommittee. It is really my pleasure to be here, and I view it as an honor and a privilege. Besides that, it's nice to get out of the shaking ground of my hometown, North Ridge, and under the solid ground of the health care debate.

I am a practicing physician, as a number of other of my colleagues are here. I am a general internist and, in the latest terminology of health care reform, I am a primary care physician. Besides that, administratively, I am the chief executive officer and responsible for a network of approximately 1,500 physicians and 75,000 patients under capitated health plans.

These patients include enrollees in commercial HMOs, Medicare HMOs, and Medicaid HMOs. Our contracted managed health care health plans include many large health plans and HMOs, including Prudential, Cigna, MetLife, and others. In my own medical office, I see patients through indemnity plans, PPOs, and HMOs. We have experience in all of these types of financing.

There is little question in my mind that there is need for cost control within our health care system and improved access for the uninsured in our communities. However, I do not think that the best health care in the world should be overturned to answer these problems of cost and access.

Furthermore, over the past few years, market forces within California have resulted in a marked slowing of health care costs and, in many instances, reductions in health insurance premiums. Let me say that Dr. Weber said, before we were talking, that California is 10 years ahead of the rest of the country.

This has been noticeable, not only for large employers, but also for small employers and their employees. The market-driven shift from indemnity insurance to managed care within California has controlled costs, and this has occurred without any governmental fiat. Health insurance premiums have not only been controlled, they have gone down over the last few years. The California public employee and retirement system is asking for a 5 percent reduction in premium in contracting with health plans. So premiums are not only controlled, but have gone down.

Additionally, the implementation of the State purchasing pool in California has enabled small businesses to purchase affordable health insurance. Independent physicians' associations, medical groups, and hospitals have been participating in true managed competition in California for a number of years, and we are experienced with capitated health plans. Our utilization of hospital bed days is less than half that in other areas of the country. We have experience in commercial HMOs, Medicare HMOs, and Medicaid HMOs.

The uninsured continue to be a problem. Please keep in mind, though, that the true, chronically uninsured population is not 35 to 37 million people but more in the range of 6 to 8 million. Let

me say, these are census studies. The average length of time of the uninsured interval is four months. Most of these people are in families that have employed people.

Insurance reform for small businesses would be beneficial in answering this problem. Community rating, guaranteed issue, no exclusions, and portability are all concepts that I strongly endorse. Small businesses should be allowed to form multiple-employer purchasing groups or join alliances in order to purchase insurance.

I oppose, however, large, exclusive alliances as defined in the administration's proposal, as this will inevitably reduce competition. I oppose the establishment of a massive new Federal bureaucracy and fear the institution of a new entitlement program. Guaranteed benefits to all Americans, without well-thought-out financing mechanisms for the present and future, will bankrupt our country.

As a health care provider I in no way can support global budgets, premium caps, or price controls. These will have inevitable dampening effects on medical technology, research and development, and are sure to lead to rationing of care. If it is rationing of care that is necessary to control costs, then let us openly debate this as a society. Let's put it on the table. Let us not hide rationing under the guise of global budgets and price controls, nor should we hide rationing within the maze of the proposed administration health plan.

Patient expectations and their tolerance for rationing are a lot different here than in Great Britain. What am I going to tell the older lady with severe osteoarthritis, that she needs to wait 13 months to get her hip replacement? What am I going to tell the 55-year-old man with the urgent need for bypass surgery, that he needs to wait a few months? And what am I going to tell the 55-year-old with end-stage renal disease, that they are too old for dialysis? Those are the types of situations that we would face as providers.

Incremental health care reform favoring a market-oriented approach would be my preference, rather than the nearly incomprehensible approach being proposed by the administration. Choice for employers and employees should be maintained. Insurance reform with community rating, guaranteed issue, no exclusions, and portability should be implemented. Small businesses should be allowed to form multiple-employer purchasing groups or alliances to contract directly with health care provider networks. This would reduce administrative costs and potentially would drive down health care costs even further.

Let me say that I do support sin taxes, such as taxes on tobacco. They are useful, public health measures and are a good way of generating revenues. Significant savings can also be realized in the Medicaid program by requiring Medicaid patients to enroll in managed care programs. The episodic care we are now providing in the emergency rooms of our hospitals to Medicaid patients is not as good as we can provide and not as good as they would receive from their own primary care physician.

According to the administration's own estimates, Medicaid savings of $65 billion could be realized over five years, and the tobacco tax would raise an additional $65 billion. This $130 billion would

more than support subsidies or vouchers for the 10 million people chronically uninsured.

Lastly, I would like to address the question of tort reform. The present liability system for health care providers and health equipment manufacturers does not work. Bad outcomes are not necessarily a result of malpractice or fault in manufacturing. At the least, limits on both noneconomic damages and contingency fees need to be put in place. At the best, the tort system needs a complete reform.

We have been successful in California in limiting noneconomic damages to $250,000, and this has resulted in a marked control of malpractice liability premiums. If you compare our experience in California to other States that do not have noneconomic damage controls, you will see the difference.

In summary, Mr. Chairman and members of the subcommittee, the choice is not between the Clinton bill and the status quo. There are other alternatives. Reform the insurance industry and make it easier for everyone to purchase affordable coverage. Let's come up with a sensible way of financing health care for all Americans who cannot presently afford it, but do not deprive Americans of the best health care and the innovations that our health care industry fosters.

Thank you very much.

[The prepared statement of Dr. Keith S. Richman follows:]

TESTIMONY BEFORE THE SUBCOMMITTEE ON
LABOR MANAGEMENT RELATIONS
COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES

By

Keith S. Richman, M.D., M.P.H.

February 10, 1994

Mr. Chairman, Members of the Sub-Committee - I want to thank you for the opportunity of testifying today at this hearing of the Labor-Management Relations Subcommittee. I would like you to know that it is an honor and a privilege.

I am a practicing physician, a general internist, and in the latest terminology of health care reform, a primary care physician. Administratively, I am the Chief Executive Officer and responsible for a network of approximately 1,500 physicians and 75,000 patients in capitated Health Plans. These patients include enrollees in commercial HMO's, Medicare Risk HMO's and Medicaid HMO's. Our contracted managed health care plans include major plans such as Prudential, Cigna, Metlife, Blue Cross along with many others. In my own medical office I see patients through Indemnity Plans, PPO Plans, and HMO's.

There is little question in my mind that there is need for cost control within our health care system and improved access for the uninsured in our communities. However, I do not think that the best health care in the World should be overturned to answer these problems of cost and access. Furthermore, over the past few years, market forces within California have resulted in a marked slowing of Health Care costs and in many instances reductions in Health insurance premiums. This has been noticeable not only for large employers but also for small employers and their employees. The market driven shift from indemnity insurance to managed care within California has controlled costs, and this has occurred without any governmental fiat. The State purchasing pool has enabled small businesses to purchase affordable Health Insurance.

Independent Physician Associations (IPA's), Medical Groups and Hospitals have been participating in true Managed Competition here in California for a number of years and we are experienced with capitated Health Plans. Our utilization of Hospital bed-days is less than half that in other areas of the country. We have experience in both Medicare and Medicaid Managed Care.

The uninsured continue to be a problem. Please keep in mind, though, that the true "chronically uninsured" population is not 35-37 million people but more in the range of 6-8 million. The average length of time of the uninsured interval is 4 months. Insurance reforms for small businesses would be beneficial. Community rating, guaranteed issue, no exclusions and portability are all concepts that I strongly endorse. Small businesses should be allowed to form multi-employer purchasing groups or join alliances in order to purchase insurance. I oppose, however, large exclusive alliances, as defined in the Administration's proposal, as this will inevitably reduce competition.

I oppose the establishment of a massive new Federal Bureaucracy and fear the institution of a new entitlement program. Guaranteed benefits to all Americans without well thought out financing mechanisms for the present and future will bankrupt our country. As a health care provider I in no way support Global Budgets, Premium Caps, or Price Controls. These will have inevitable dampening effects on Medical Technology, Research and Development, and are sure to lead to rationing of care. If it is rationing of care that is necessary to control costs then let us openly debate this as a society. Let us not hide rationing under the guise of Global Budgets and Price Controls. Nor should we hide rationing within the maze of the proposed Administration health Plan. Patient expectations and their tolerance for rationing are a lot different here than in Great Britain or Canada.

Incremental Health Care Reform favoring a market oriented approach would be my preference rather than the nearly incomprehensible approach being proposed by the Administration. Choice for employers and employees should be maintained. Insurance reform with community rating, guaranteed issue, no exclusions, and portability should be implemented. Small businesses should be able to join multi-employer purchasing groups or alliances for the benefit of purchasing insurance. Allowing multi-employer purchasing groups or alliances to contract directly with Health Care Provider networks would reduce Administrative costs and allow for more competition. This will drive health care costs down further.

Sin taxes, such as a tax on Tobacco, are not only useful public Health measures but are a good way of generating revenues. Significant savings can also be realized in the Medicaid program by requiring Medicaid patients to enroll in Managed Care programs. The episodic care we are now providing in the Emergency Rooms of our Hospitals to Medicaid patients is not as good as they would receive from their own Primary Care Physician. According to the administration's own estimates Medicaid savings of $65 Billion could be realized over 5 years and the Tobacco Tax would raise an additional $65 Billion. This $130 Billion would more than support subsidies or vouchers for the 10 Million people "Chronically Uninsured".

Lastly, I would like to address the question of Tort Reform. The present liability system for Health Care Providers and Health Equipment Manufacturers does not work. Bad outcomes are not necessarily a result of Malpractice or fault in manufacturing. At the least, limits on both non-economic damages and contingency fees need to be put in place. At the best the Tort system needs a complete reform.

In summary, Mr. Chairman and Members of the Subcommittee -- The choice is not between the Clinton Bill and the status quo. There are other alternatives. Reform the insurance industry and make it easier for everyone to purchase affordable coverage. And lets come up with a sensible way of financing health care for all Americans who can not presently afford it. But do not deprive Americans of the best health care and the innovations that our health care industry fosters.

Thank you very much.

Chairman WILLIAMS. Thank you.

Our final witness is Dr. Sim Rubenstein, who I think came out from Seattle, Washington, to be with us. We appreciate it.

Being from Montana, I know about traveling across this wide country, and we appreciate your being out here.

STATEMENT OF DR. SIMEON A. RUBENSTEIN, SEATTLE, WASHINGTON, MEDICAL DIRECTOR FOR CORPORATE HEALTH, GROUP HEALTH COOPERATIVE OF PUGET SOUND

Dr. RUBENSTEIN. Thank you, Mr. Chairman and members of the subcommittee.

My name is Simeon Rubenstein. I am the medical director for Corporate Health, Group Health Cooperative of Puget Sound, and a practicing cardiologist. I also chair Group Health's Technology Assessment Committee and Benefits Committee.

Group Health Cooperative is a 47-year-old, consumer-governed health care system which integrates financing and delivery through a mixed staff and contract provider model. It serves a broad spectrum of enrollees, geographically, throughout the State of Washington and Northern Idaho, both urban and rural. The funding of premiums comes through individuals, through employers, managed Medicaid, Medicare risk contracts, Federal and State enrollees, and the innovative Washington State Basic Health Plan.

Health care reform in Washington State is evolving through market forces and through recently legislated reform, legislated but not yet implemented. Group Health's community leadership has brought focus to many things, including the underserved, as well as the so-called well-served populations. My goal is to tell you what we are doing today to serve inner-city and rural populations in an evolving market and how health care reform can enhance our efforts.

Today, we identify enrollees in a noncategorical way. Whether premiums are paid by business, individuals, Medicaid, or the Washington State Basic Health Plan, providers like myself are blinded to the funding category. We have constructed and staffed clinics, area medical centers, in previously underserved areas, particularly in the Seattle metropolitan area.

We staff community clinics, serving non-Group Health patients, with physicians and pediatric nurse practitioners, as well as giving them logistical support. We sponsor multiple community outreach programs, prenatal care and delivery to low-income women who are non-Group Health enrollees, as well as immunization programs.

We link with and support physicians in small communities throughout Washington State and Northern Idaho by giving them educational support, staffing, including recruitment and locum tenens support, as well as administrative support. We do this in communities down to 2,000 to 4,000 size population, as well as one community of approximately 700.

Federal health care reform and how you can help us further: The market is moving fast, reshaping health care. Reform that builds on these market forces is far more likely to be accepted. You can help us facilitate those market forces and guide the market evolution. We need to improve real, informed choice for our patients and consumers and members of our State. Uniform benefits and

similar reporting will allow individuals to focus on cost and objective measures of quality.

Insurance reform, which almost everybody agrees on, including insurance companies, portability, no preexisting conditions, open enrollment, will stop the revolving door of people being in or out of some of our publicly-supported systems. Expanding the insured population through appropriate premium payments that are based on risk is a powerful incentive to expand further into inner-city and rural areas.

In summary, Group Health and other integrated health care financing and delivery systems provide an effective approach to serve, at least in part, the needs of urban and, more recently, rural communities. A number of Federal legislative proposals are compatible with the evolving market forces and the legislation currently enacted in the State of Washington.

Thank you.

[The prepared statement of Dr. Simeon A. Rubenstein follows:]

Simeon A. Rubenstein, MD

I. Introduction

Mr. Chairman, members of the Subcommittee, I am Simeon Rubenstein, Medical Director for Corporate Health, Group Health Cooperative of Puget Sound and a practicing cardiologist.

Group Health Cooperative is a forty-seven year old integrated healthcare system (HMO) that has a well-deserved reputation for providing excellent healthcare services to a large population in the Puget Sound area, across the state of Washington, and into northern Idaho. Among Group Health's 500,000 enrollees are approximately 46,000 Medicare, 8,000 Medicaid, 65,000 federal enrollees and 74,000 state government enrollees. GHC also cares for 7,200 enrollees from the Basic Health Plan, which is a model state-subsidized program for low-income, non-Medicaid eligibles. Capitated Medicaid enrollment is expected to increase to 18,000 by the end of 1994, and Basic Health Plan enrollment is expected to increase as well. Group Health's community outreach programs have also contributed to the health of the larger Puget Sound community.

In April 1993, the state of Washington passed a comprehensive healthcare reform act. An employer and individually financed, managed competition model is now law. Integrated healthcare systems (HMOs and managed care) for financing and delivering healthcare services currently exist and are being created to compete in this new environment.

II. Serving poor and underserved populations

One concern raised by our community and public policy makers has been: Who will serve the poor and underserved markets; that is, those in the inner cities and rural areas of our state? While social issues such as housing, education, and nutrition undoubtedly contribute to the poor health of our underserved populations, there are also limitations in access to health services that are broader than just financial access. There are also major limitations in geographic access (such as, lack of local providers and facilities) and social access (language, culture, and provider ethnic differences). These social barriers can prove to be larger than the financial barriers.

While awaiting implemenetation of state legislative healthcare reform, GHC has contributed to improved healthcare access for the poor and underserved populations of our community through a number of activities:

- Group Health enrollees are identified in a non-discriminatory manner. Irrespective of their financing source, all enrollees carry the same type of identification card. All enrollees can access any and all of our ambulatory clinics, specialty centers and hospitals without categorical discrimination. From the provider standpoint, the source of premium payment (whether

individual, group, Medicaid or the Washington State Basic Health Plan) is blinded.

- Group Health has purposely built and staffed clinics in neighborhoods previously underserved. The Rainier Medical Center in Seattle is a facility built and opened in 1982 to directly serve a relatively poor area of the city. Though a financially unprofitable clinic in the first few years of existence, the need to meet the geographic standards of all of our enrollees necessitated the establishment of this medical center.

- Group Health Cooperative offers support to existing community clinics in the Puget Sound area by providing physicians and pediatric nurse practitioners. These providers, employed as part of the GHC medical and nursing staff, help fill a void in the existing community clinics serving non-Group Health patients.

- Group Health Cooperative, through its Center for Health Promotion, has developed various community outreach programs, including the provision of prenatal care and delivery to over 200 Medicaid-eligible women each year, and the operation of pregnancy and parenting clinics for high risk teens and teen parenting support groups. Other outreach programs immunize homeless children and provide nurse practitioner services in daycare centers, schools, shelters and homeless clinics.

- In rural areas, Group Health has linked with local physicians in small communities throughout the state. We are locating or contracting with providers in communities with populations as small as 700 people. Those physician can then serve a wider catchment area. Providing educational support, locum tenens staff and administrative skills, we are developing an integrated network that serves urban and rural, inner city and suburban enrollees.

III. Cost and Quality

HMOs provide care that is of equal or better quality than that given in fee-for-service settings. This can surprise those who have only second-hand knowledge of HMOs. For example, an in-depth investigation by *Fortune* of HMOs yielded a surprisingly impressive picture. Clinical studies showed that the care received by HMO patients is at least as good as that received by other patients.

Group Health has often participated in such studies, including the Rand Corp.'s landmark Health Insurance Experiment. The study reported:

- Hospital outcomes: Cost savings were not reflected in lower levels of health status.

- Surgery rates: There were no observable adverse effects on health from the lower rates of nondiscretionary hospitalization.

- Ambulatory care: Persons randomized to an HMO had slightly better overall quality of care than those in the fee-for-service system.

- General outcomes: For most people, GHC saved money and, if anything, may have been better for health.

Since care is given on a non-discriminatory basis, all populations (patients and payers) enjoy these benefits.

IV. Healthcare reform and enhancing service to the currently underserved

Group Health is only one example of respectable organizations that can effectively serve broad community healthcare needs. The members of this Subcommittee, Congress, and the President can improve the development and growth of integrated systems for healthcare financing and delivery to include rural and underserved populations:

- Legislation should enhance the market forces that are currently reshaping healthcare.

- A leveling of the playing field can be enhanced with insurance reform, uniform benefits, and similar reporting requirements on performance. Buyers can then make informed decisions on the basis of cost and quality.

- The premium level and subsidization of publicly-funded programs needs to be market based and appropriate to balance population risk.

- Expanded consumer financial access through insurance forms a powerful incentive for the expansion of healthcare delivery system capacity and locations.

- The availability of well-trained providers that meet the cultural needs of our increasingly diverse population must be enhanced

- All populations, irrespective of the source of premium financing, need to be treated in a non-discriminatory way that meets the access and quality standards of the organization.

V. Conclusion

In summary, Group Health and other integrated healthcare financing and delivery systems provide an effective approach to serve—at least in part—the needs of urban and, more recently, rural communities. Federal legislative proposals are compatible with the evolving market forces and the legislation passed in the state of Washington.

Thank you

BIOGRAPHY

Simeon A. Rubenstein, MD

Dr. Rubenstein is the Medical Director of Corporate Health, Group Health Cooperative of Puget Sound and the Associate Director for Policy Development.

Dr. Rubenstein's clinical background is in cardiovascular disease. After completing his cardiology fellowship at the University of Washington in 1974, he was Acting Director of the University's Echocardiography Laboratory from 1975-1978. He is currently a Clinical Professor in the Department of Medicine, a fellow in the American College of Cardiology, and past president of the American Heart Association, Washington Affiliate.

Dr. Rubenstein was Chief of Staff, Central Region from January 1983 - December 1991. In 1981 Dr. Rubenstein developed Group Health's Technology Assessment Committee and has served as chair since its inception. From 1993 to present he chairs the Cooperative Benefits Committee. He is a diplomat in the American College of Physician Executives.

Dr. Rubenstein completed flight surgeon training at Brooks Air Force Base in 1969 and served two years in the US Air Force from 1969-1971.

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Chairman WILLIAMS. Thanks to each of you.

Dr. Duvall, I had read press accounts, apparently inaccurate, given your testimony here today, that the AMA had opposed employer mandates. You say, on page 2 of your printed testimony, "We support a variety of approaches to achieve this goal," the goal being universal coverage, and among those approaches you list employer mandates.

Does the AMA support employer mandates?

Dr. DUVALL. Yes, we have for quite a long time, Mr. Williams.

I can remember, about two weeks after Gail Wolinsky was confirmed, we presented our plan, which mentioned only employer mandates. We have not swerved from that idea as a very important part of health care reform financing. But we realize, in the spirit of compromise, which you alluded to earlier, that there may be other ways of skinning the cat: individual mandates, and another example would be the health IRA. There is no reason why a health IRA can't be a compatible part of some plan, even of employer mandates.

So we are willing to talk with everyone on this.

Chairman WILLIAMS. Thank you.

We find on this panel, as I mentioned to you, as most of us have as we have gone around the country, that most health care providers support universal coverage, although there is some disagreement among the panelists here about that.

Another area of contention, I suppose, or disagreement, with this panel, appears to be the best method of controlling costs. Poll after poll after poll shows that the American people place that number one. Now, these are the same American people that don't want to disturb quality. Nonetheless, they want costs reduced. There's no question about that.

My own judgment is that this Congress is going to vote to do something about costs of health care. Now, the question is, how do we best do it in order to meet the demands of the American public, because that's, after all, why we are elected.

Dr. Weber believes that global budgets are necessary; other witnesses oppose them. Let me assume for a minute that you all agree that controlling costs, in some manner or other, ought to be an objective of reform. What do you recommend in place of the administration's caps on spending and premium increases and the global budget requirements of the single payer proposal? How would you control costs?

Anybody want to answer that?

Yes, sir, Dr. Murray.

Dr. MURRAY. Well, I think that a budget is an obvious necessity. We have one in our own home. We have one in our business, et cetera. There is a point at which you have to allocate a certain amount of money to achieve a certain level of productivity. We accept that in the American College of Surgeons.

I think the issue in controlling costs is to look at where the money goes. There is a potential for starting a program, for instance, covering everything, running out of money, and then looking, where do we cut costs in order to bring this back under the budget? The alternative is to be very careful in starting a program with basic coverage, assure that the primary things that need to

be covered are covered, and then, eliminating waste, expand the coverage, if the money is available.

I think that there are fringes of coverage that sound good on paper that are not necessarily necessary.

Chairman WILLIAMS. Mrs. Roukema, do you have a question or two before we go vote?

Mrs. ROUKEMA. Well, I really had other questions, but Dr. Murray has now stunned me again. What did you mean by that last statement?

Dr. MURRAY. I think that, if we have a budget for health care, which I think we must have——

Mrs. ROUKEMA. Yes, a budget for health care.

Dr. MURRAY. [continuing] then what is that budget going to cover? I think that is where we have to take a careful look.

Mrs. ROUKEMA. No, you said the fringes. Name some of the fringes that you don't think should be covered.

Dr. MURRAY. A patient comes in to my office after having hip replacement, and I say, "Now it's time that you can move to a cane." They start out, they come back, and they say, "Well, my insurance covers that cane if you will write me a prescription." So I write them a prescription, and they take it to the pharmacist. They fill out forms. I get a form back. I fill out the form, send it to my secretary, she sends it back, et cetera.

A cane does not cost a lot of money, and there are a lot of them around. These types of things, I think, are instances where we can look at how we can save money without influencing quality.

Mrs. ROUKEMA. Well, I think we would all agree with you there. The problem is, I don't think those are big numbers, and they don't come anyplace close—that kind of thing doesn't come anyplace close to covering the margin.

Mr. Chairman, I have a couple of very serious questions to ask, and I think maybe we ought to recess and come back.

Chairman WILLIAMS. All right. Mrs. Roukema and I will go over and vote on the issue at hand on the floor, and we will be back inside of eight or nine minutes. We appreciate your courtesy in remaining.

If any of you find it impossible to remain, we will understand your absence upon our return.

Mrs. ROUKEMA. I did want to say, for Dr. Richman, that his congressman, Congressman McKeon, will be back. He wanted you to know that. He just went to vote, and he will be right back.

Dr. RICHMAN. I'm not worried.

Mrs. ROUKEMA. Hope you don't go anyplace.

Chairman WILLIAMS. Okay.

[Recess.]

Chairman WILLIAMS. Maybe our witnesses can reassemble.

Let me ask another question. I think maybe I have another minute or so remaining, and then we will go to the ranking member.

Dr. Richman, although you, like all of our witnesses, and I think like everyone in the country, support some reforms, including insurance reforms, it seems to me, from hearing from you as well as looking at your testimony, that you would continue the current voluntary system. Maybe we ought to do that, but the question for us

is, how do we control costs and eliminate cost-shifting if we don't bring everyone into the system? Can you give us some counsel here?

Dr. RICHMAN. This is going to be a long-winded answer, Mr. Chairman, because I don't have an easy answer to control of costs.

Chairman WILLIAMS. Make it long-winded within two minutes, so I can stay within my own time limit here.

Dr. RICHMAN. Okay. The first problem that I think we need to address, in looking at costs, is cost generators and technology and the aging of the population. So I think, if the Congress looks, as an example, at what medical technology and drug industries exist in Canada, I think that they would see that there are not many under global budgets or price controls.

The aging of the population also concerns me greatly in controlling costs, and I don't have an easy answer for that one. Twelve point five percent of the population presently is over age 65, and in the year 2015, when I will be age 62, approximately 20 percent of our population will be over age 65. I don't have an answer for controlling those costs and limiting resources. I think that there is going to need to be rationing of care, and that's going to need to be put on the table.

I also think it is important to recognize, though, that there has been a very good experience in California in controlling costs with market forces. I also think specifically allowing alliances of employers, multiple-employer groups, to contract directly with provider networks, similar to what the American Hospital Association is putting forth, would reduce administrative costs and would take out the insurance companies as the middle man between the buyers of health care and the providers. I think, to remove the insurance companies from that position would be a good initiative.

Let me say that we are doing administrative costs in our system in the range of 2 to 3 percent of premium, which is similar to what Medicare is doing. Those are specific examples of cost control.

Chairman WILLIAMS. There is kind of a gatekeeper rationing plan assumed by a number of the proposals that are before us, so I think a number of people, probably including supporters of the President's plan, would agree with you about rationing. The question is, how do you do it, and is it politically feasible? I don't mean political bumper sticker in November feasible, I mean, is it politically feasible in this society, and that is questionable.

I think the President would agree with you—in fact, I know he would. I have talked to him about it. He thinks market forces ought to be unleashed in some way or other to try to bring down costs. It's just that, I guess, he would do that a little differently than you would. The provider networks exist now and have done very little to restrain costs.

Dr. RICHMAN. Mr. Chairman, let me say, in California we have worked under a full-risk capitated program, as providers, now for eight years. So we have worked under a fixed budget. If you want to know how to do it and you want to get experience in having physicians and providers working under a fixed budget, I will be happy to tell you that. That would be a very long-winded answer.

Chairman WILLIAMS. We have been working with some folks in California who are familiar with that and have been giving us some good counsel. Thank you.

Mrs. Roukema.

Mrs. ROUKEMA. Yes. Mr. Chairman, I am going to defer, for the first question, to my colleague from California. He has his constituent here, and I think he wants to both greet him and ask some relevant questions.

Chairman WILLIAMS. The gentleman from California.

Mr. MCKEON. Thank you, Mr. Chairman.

Thank you, Mrs. Roukema.

I appreciate greatly the opportunity of having Dr. Richman here. He is from our district. He is a highly respected physician and leader in the community, and it's a real pleasure having him here. He has also served as leader of our health care task force in the community.

I know we have spoken in the past. We have talked to other physicians. We have talked to hospitals, other medical care providers. You mentioned, in your testimony, Dr. Richman, and in a follow-up answer, you talked about rationing. Maybe you could expound a little bit more on that.

I would also like to hear—you talked about your history with malpractice insurance. If you could maybe expand a little bit on your experience with malpractice reform and what has happened to premiums for physicians there.

Dr. RICHMAN. First of all, on rationing, let me start off at the level of the President's health alliances. The President, in his proposal, presumes that there would be three types of health plans: fee-for-service, PPOs, and HMOs. But in the health plan he limits the premiums that would be available in those health plans to 20 percent above the average. Inevitably, that will put fee-for-service plans out of business. They will not be able to compete. Their premiums will not be within 20 percent of the average premium. And they will not be offered to patients within the alliances.

So fee-for-service, although stated to be available in the President's plan, in all likelihood will not be available because of the limitation of the 20 percent premium.

Secondarily, if you read the President's plan, if a favored health plan is oversubscribed to, good providers, good doctors, there is a lottery process in which patients arbitrarily are chosen to go to other health plans. So if you signed up for a particular health plan that you wanted to be a patient of, and that plan was oversubscribed, then you would be forced into another plan.

Now, let's go to the question of global budgets and premium caps. If you look at systems like the Canadian system, where there are global budgets, there is a marked control of capital expenditures. People in Canada come down to this country for radiation therapy. There are delays in coronary artery bypass surgery. There are delays for hip replacements. There are delays for all those types of services.

Those are services that are rationed simply by the prolonged wait. What we're talking about is waits of greater than a year for hip replacements, months for bypass surgery, six or seven months for routine services like mammograms or Pap smears.

Let me transition from rationing to tort reform. There is an interesting story. If you are in Canada, you don't have the availability of the most advanced chemotherapy for breast cancer. Okay. They will give first-, second-line therapy for breast cancer. In our country, if you don't provide bone marrow transplantation for breast cancer, you get sued. The health plan gets sued.

There was recently a suit in California with Health Net in which the award was $89 million because the patient did not receive bone marrow transplantation for breast cancer. That therapy wouldn't be offered in Canada. So that ties into malpractice.

The particular experience in California regarding tort reform is that there has been a program called MICR in place for the last number of years, which is controlled noneconomic damages to $250,000, and that has put a marked slowing on the premiums, liability premiums, for malpractice insurance. Our premiums in California, compared to States like Michigan, Florida, and New York that do not have controls on noneconomic damages, have much higher premiums than in California.

We think that's very important. It is hard enough practicing defensive medicine, constantly worrying about getting sued. Just controlling the growth in malpractice insurance would be a good first step.

Mr. MCKEON. Thank you very much.

Chairman WILLIAMS. Mrs. Roukema. You still have time remaining.

Mrs. ROUKEMA. Well, I'll take my time later. Thank you.

Chairman WILLIAMS. I know Mr. Payne was here earlier. We try to go in order.

Mr. Payne, am I right about that?

Mr. PAYNE. Thank you.

Well, you were here earlier.

I will yield to Mr. Engel.

Chairman WILLIAMS. Was Mr. Engel here first?

Mr. PAYNE. Yes, he was.

Chairman WILLIAMS. Mr. Engel, we are glad you are here. Please proceed.

Mr. ENGEL. Thank you, Mr. Chairman.

Dr. Murray, I have just come from a vote, and your testimony has made its way all the way to the Capitol. Things happen very quickly in Washington. I am told that you made a statement that your organization and yourself have favored the single payer plan. I would like to ask you, for the record, is that what you said? Because it was not in your written testimony, and I would like you to reiterate it and expand on it, if you can.

Dr. MURRAY. I think the point that I want to make is that the American College of Surgeons is committed to the concept of universal access to health care, to the quality of care provided, and to the ability of patients to select the physician or surgeon of their choice.

It is our conclusion, after careful reviewing of the current proposals out there for health system reform and also the current changes in the delivery system that are going on without any legislative health care reform, that we would endorse a single payer system as the best method for ensuring that the patients receive consist-

ent, cost-effective, and high-quality care at the most manageable cost.

Mr. ENGEL. Do I take it that you believe that single payer would be the best vehicle to provide universal coverage?

Dr. MURRAY. That's correct. I want to make it very clear, we are not endorsing a plan. Up to this point, we have not endorsed a plan or come out with a policy or position on health care reform, because we were interested in seeing the panorama of plans that became available and the ebb and flow of ideas. At this point, this is what we have concluded, looking at the situation, a concept of a single-payer system.

Mr. ENGEL. What about the stability of the financing under a single-payer plan, are you convinced that it is stable or would be the most stable?

Dr. MURRAY. We have been involved with the Medicare payment system for several years now, and we have supported the issue of a budget for Medicare. In fact, we recommended and received a separate MVPS for surgical care, which gave us a budget to look at within surgery, and in fact we have met that target for the past two years.

Therefore, I think, from our standpoint, it is eminently possible to take a look, within the framework of a single-payer system, which that represents, and evaluate budgets, and then work to meet those goals.

Mr. ENGEL. What about the managed care insurance versus Medicare? You indicated that the aggravation or the hassles that are received from managed care insurance are much greater than those received even by Medicare. Can you tell us a little bit about that?

Dr. MURRAY. The concern we have is that, in some instances, and I won't say this crosses the whole field, but the emphasis is on cost control within that segment. The emphasis seems to be less so from the Medicare standpoint. We take care of Medicare patients as we see fit. We take care of patients otherwise as the insurance company sees fit. We are told that they can come in only on the morning of surgery, for instance, even if they live 100 miles away. We are told that they must be discharged after four days following a hip replacement. We are told what we must do, in one regard or another, or else we have to, obviously, seek permission to get variances, one thing and another.

These are issues that are becoming increasingly onerous and are, in some cases, we are concerned, affecting the potential quality of care.

Mr. ENGEL. With managed care insurance?

Dr. MURRAY. Yes, with insurance which is directed toward cost control. I must say that there is an issue which disturbs many of us, and that is, we are shifting from a system whereby physicians' incomes are determined not by how much care they give but by how little care they give. And we are entering that kind of—it's a discouraging thing to see happening.

Mr. ENGEL. Thank you very much.

Thank you, Mr. Chairman.

Chairman WILLIAMS. Mr. Gunderson.

Mr. GUNDERSON. Thank you, Mr. Chairman. One of the things I have learned in this committee is that, if you want to have influence with the Chairman, you ask his witness the first question.

So I am going to ask Mr. Flink, you're on board here, can you expand for us—and, hopefully, quickly, because I have a number of questions—the rural aspects of the Clinton plan and what you would like to see added to that.

Mr. FLINK. I think the primary concerns that rural areas such as those in our State have are centered around the role and shape of the alliances and the accountable health plans and those sorts of things.

As you know, having been in our State, there are very few two-hospital towns. Most places where there are hospitals, there is only one hospital in the community, and often one or two physicians there to serve the people. There is a fear that somewhere in this process the people in these communities are going to lose access to those services.

I think, how the accountable health plans are shaped and how the alliances are put together, assuming the Congress chooses to adopt that route, will be something that could have a major impact on those rural areas.

Mr. GUNDERSON. Thank you.

Dr. Duvall, this is a long, complicated request, so I would appreciate it if you would provide it for the record, we need some information and suggestions on how to design the antitrust section of this legislation. I am particularly concerned, from a rural area, before we run amok in giving too much antitrust exemption, that we have some requirements and conditions of service in order to achieve that antitrust exemption.

Could you personally, or on behalf of the AMA, submit some thoughts to this committee on that?

Dr. DUVALL. We would be very happy to do that and help work with the language and the concepts of it. The antitrust thing for us comes down very close to being a proxy for quality in this health care environment which is so competitive. I think we have cut a lot of things right to the bone, and the bone marrow is the quality of this. So we would be very anxious to work with you on that.

Some of these antitrust considerations, numerical targets for safe harbors, they just don't work. In a small community, if there are six doctors and if there are three of them that get together to do something, well, they are in, per se, trouble all of a sudden. So there have to be definite considerations for the special rural——

Mr. GUNDERSON. Well, yes. The problem is—Mayo is in my area, and I have told the head of Mayo this—I am not ready to give an institution like the Mayo Clinic antitrust authority to create a regional medical delivery system today that, once they have taken over all the delivery, 5, 10 years from now they are able to then start paring back services in certain areas.

If we are going to give them the ability to reduce overhead and have a regional delivery system, we have to have some assurance, on the other side, of a commitment to service, especially in those rural and underserved areas, per se.

Dr. Weber, similar for you, you are supporting employer mandate. I would love to have you define what you mean by employer

mandate. Do you mean the employer is the point of access for coverage or the employer subsidizes? I don't think there are votes in the Congress for the employer mandate provision, in terms of subsidy of payments today, but I think there are to make sure that is the point of coverage for insurance.

I also would like you to submit to this committee your definition of what you mean by preventive and primary care and how we calculate that as a benefits package. One of the problems with CBO's analysis of the President's plan is, it is going to cost a lot more than the President thought, which is what I think all of us have feared a long time. Now we are going to have to bring all this back to budget reality. What is the process we should use to do that, and what is the definition of a benefits package that should be included in that, if you would?

Dr. WEBER. Okay. The first, we have a formal definition of preventive care, and it is very detailed. I would be very glad to furnish that to you. It is probably even more detailed than the Health Security Act. It tells those tests that would be necessary to diagnose the major illnesses, the cancers, the vascular disease, that really are asymptomatic. As you know, the first symptom of a heart attack is sudden death.

Mr. GUNDERSON. Can you submit them for the record? I'm running out of time here.

Dr. WEBER. Yes.

Mr. GUNDERSON. Can you give us the detail?

Dr. WEBER. Sure.

Mr. GUNDERSON. I want to ask Dr. Murray a question.

You may have to submit this for the record, but, Dr. Murray, I am totally confused by your statement. I want to read from your public statement here where you say, "The President's plan calls for a major restructuring of health care. All sorts of new boards, corporations, and other quasi-governmental alliances would be created throughout the country. At a time when we should be streamlining our system and reducing bureaucratic and overhead burdens, which drain funds that could be used to provide health care services, we find this disturbing."

How you can say this in your statement and then conclude that we ought to have a single payer? I'm confused.

Dr. MURRAY. I don't think the two are mutually exclusive at all. I think, in the President's program, he has set up a system which is not a single-payer system; it is a multiple-payer system. In order to manage that, there are numerous levels, some of which, even after study, I don't understand what the levels are.

I think we are looking at a single-payer system, in terms of simplifying that management system that just becomes overwhelming when you try to cover the country with numerous providers, payers, et cetera. So I don't think it is mutually exclusive.

Mr. GUNDERSON. I'm out of time. Dr. Weber, in particular, I would appreciate it if you would submit that for the record, because we don't have enough time.

Dr. WEBER. We will do that.

Mr. GUNDERSON. Thanks.

Chairman WILLIAMS. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

I appreciate the panel being here because it is such a varied group. Our committee is going to spend a lot of time listening to lots of the experts.

I was reading over each of your testimonies and I think, to a person, each of you addresses or supports the issue of universal coverage, to some extent, or universal care. And I think only one person talked about universal access. So we know, at least, the President drew his line in the sand, as we say in Texas, and said "universal coverage." We have some unanimity in trying to reach that.

One of the other issues I have talked about with the folks in my district is the issue of global budgeting, in particular, with the hospital association in Houston. And I know, Dr. Weber, you talked about the support for global budgeting. My response—because, before I was elected to Congress, I served on a hospital board, and we had our budgets we had to live with. Granted, with uncompensated care, we always didn't hit our marks that we wanted.

There is already—even though we don't call it global budgeting, there is budgeting now. And I would like Dr. Weber to talk about how your group reached the support for that global budgeting?

Dr. WEBER. Well, we felt that budgeting was part of any cost containment program. You have to have a target, and you have to know where you are. Now, our plan doesn't have alliances, but it does have a national health board which is charged with the global budgeting. And in our plan it is enforceable, but it really is not made punitive.

I think you have to have budgeting, and I think you have to have the ability to enforce a budget, for survival under certain circumstances, but I think that our budget would be for the purpose of good management, not a punitive purpose. The cost overruns should be put back on where the cost overruns came from, for example, not on everybody.

Mr. GREEN. Mr. Flink, if you could address that, because, again, that is my experience, outside of being a patient, is the hospital board. I know we had budgets. We didn't call them global budgets. It was a for-profit, nationwide chain, so we had to go back to our home office to get approval or any other changes in what we were doing.

Could you address that?

Mr. FLINK. I think our position on this is that budget targets are certainly a very useful way to measure health spending. However, mandatory global budgets set and determined in Washington, and imposed in rural Montana, or rural Texas, or wherever, are not the most flexible way of providing the health care needs of your community.

The bottom line for us is that we are here to serve the communities and to provide health care services that they need. And the community should determine what those services are, and what it is going to cost to provide them then kind of flows from that decision.

I know, from our personal experience in Montana, we have quite a different cost structure in our hospitals than you would in New York City. A global budget that is set nationally just isn't going to be applicable to our situation. So we are looking for more flexibility and targets.

Let me say one final thing on that. If the targets are missed, or spending exceeds the targets, then it is the role, we feel, of an independent commission to determine why costs exceeded the targets. Perhaps, you know, there has been an outbreak of some major disease, perhaps earthquake victims caused hospitals to provide more care. We feel we need that kind of flexibility to serve our communities appropriately.

Mr. GREEN. I don't think we are that far apart. We realize, even though Congress is probably not a great example of setting budget and targets, but we all know that there are extenuating circumstances lots of times, but we have to have some kind of budget that you live under.

Dr. Richman, let me ask you about your rationing of health care. I come from an inner-city district, and even though we have a lot of industrial base, I have a lot of people who don't have access, or at least they can't afford it, or their employers don't provide it now.

Again, in talking with lots of constituents, I feel like there is some rationing going on now. We don't call it that. Just because people don't go for preventive care, because they don't want to spend the $50 to go to their physician, you know, they wait until it's an emergency, and they show up at our emergency rooms, and they really don't need to.

Can you address the rationing of care, comparing what you see as the President's plan, or as compared to what is happening currently, say, in a rural area, or in an inner-city area like I represent?

Dr. RICHMAN. The simple answer is that I agree with what you are saying, as far as rationing of care to those people. I don't like seeing people in the inner-cities, or low-income people anywhere, who are not getting care. I have also been the chairman of the free clinic in our area and have been responsible for growing the budget and taking care of those people.

So, in fact, I agree with you and feel that those people need to be taken care of. That's where my comments came in about the need for subsidies and vouchers for low-income people and possibly for small businesses. I don't think that the bureaucratic maze that is being put in in the Clinton plan is what is necessary to do that.

I think, if you look at the uninsured numbers and you go back and look at the census data, and really look at the chronically uninsured, which is what you are talking about, not the people that go on and off the uninsured rolls, that that number is a whole lot less than 35 million or 37 million people.

There is little argument on that. I mean, get the government data. We can say that it is 10 million, at a high number, and simply apply a broad-based coverage package, present cost, and use round numbers of about $2,000 per person. That would cost about $20 billion per year. I think we need to take care of those people, and that $20 billion per year needs to come from somewhere to support those people.

Mr. GREEN. These are the working poor, for example, who aren't eligible for Medicaid.

Dr. RICHMAN. Well, that's exactly right. People who are eligible for Medicaid are not uninsured.

Mr. GREEN. I know.

Dr. RICHMAN. Medicaid is one reason to leave the uninsured rolls. I'm talking about those people who are in the middle, okay, and I'm talking about building in sliding subsidies built on level of poverty, and allowing those people to purchase health insurance. I agree with that.

Chairman WILLIAMS. The gentleman's time has expired.

Mr. GREEN. Thank you, Mr. Chairman. I know my time has run out.

Chairman WILLIAMS. Mrs. Roukema.

Mrs. ROUKEMA. Thank you, Mr. Chairman.

I do appreciate this discussion so far, and it has been very informative, in some ways. I appreciate the fact that someone has finally said the dreaded thing, which is that really what we are talking about here is rationing of care, that all the cost-benefit analysis comes down to that.

Well, as you heard from my opening remarks, I am not yet willing to accept that. Therefore, I would like to hear the panel react to what is my tentative conclusion—it's more than a tentative conclusion; I think it is becoming a dictum—and that is that we can't do all this now, that there are too many unknowns, and that maybe, since what we are talking about is a health insurance crisis, that we ought to take the first step, which is a giant step in itself, if we do it, and that is, take care of the insurance funding issue.

How we do that is another question. We have to cover portability. We have to cover the cherry-picking or the lack of continuance of issue, whatever they call it, you know, cancellation. You know the sick joke: You only get insurance in this country as long as you are all healthy. You get sick, forget it; it gets canceled. We have to deal with that. And the part-timing of America, which, for a number of economic reasons, not the least of which is the health insurance question, more and more companies are moving to part-time employees.

That is the crux of the anxiety and panic that is facing the American people. Can any of you help me with that? From your perspectives, can you see how we can do that and then put off this question of cost-benefit analysis? By the way, it will have to be done with some element of tort reform, I understand, but I think that's going to be the hardest part of it, tort reform.

Yes, Dr. Richman. I will take you in the order in which I see your hands. Then Dr. Duvall.

Dr. RICHMAN. I think I would agree very much with what you are saying. I think, if the Congress did two things: one, put in insurance reform; and, two, cover the uninsured population, that I think it was Congressman Green was saying——

Mrs. ROUKEMA. The low-income? You are talking about the low-income?

Dr. RICHMAN. Right.

Mrs. ROUKEMA. Yes, we need some sort of an insurance pool for that.

Dr. RICHMAN. Those two things would go a long way. In putting in the insurance reforms that you are asking, personally, I would say no preexisting exclusions. Allow portability. Allow businesses or the development of alliances, voluntary alliances, which people

can purchase their insurance through, carry it forward. We are doing that in California. People can purchase affordable insurance.

Mrs. ROUKEMA. Isn't that expensive?

Dr. RICHMAN. No. The way the California health insurance purchasing plan has evolved is, it is essentially a State pool where the various health plans within the State submit their premiums on a community-rated banding, by ages, and then——

Mrs. ROUKEMA. Community rating.

Dr. RICHMAN. Community-rated in age bands. I think it's five bands. So a 20-year-old is not paying the same as a 45-year-old. Then the insurance companies submit their bids, and then people have the opportunity to choose whichever plan they want to pick. In fact, those rates are as affordable as nearly a federally-qualified HMO would be to a large group employer. You have the same companies offering the health plan.

Mrs. ROUKEMA. Okay. Dr. Duvall, Dr. Weber, Dr. Rubenstein. I hope we have enough time. Everyone.

Dr. DUVALL. Thank you for your very important question. I certainly agree that we do need to have reforms of those parts of the insurance industry that are at fault right now, but I think we really can do more. I think really everyone is for some reform or substantial reform. Maybe we are not for transformation. Maybe the alliances, with a whole bureaucracy and central planning, with a fixed global budget by a very powerful board, maybe that's too much, in terms of transformation.

We were asked earlier about cost containment, and we have mentioned, particularly in my testimony, quality. These are things that require broad-based reform. We can get $29 billion out of defensive medicine. By unleashing competitive forces, which, I think, someone quoted the President as wanting to do, we can save money there, a la the testimony from California. There are a lot of things we can do, but I think we can do it within the spectrum of broad reform.

We have to be very careful. Now that we have the genie of price contained, cowering in the corner—it may not be totally brought to heel, but we have the thing sort of cornered and under some kind of control—that's when quality becomes so important, and that's where physicians have to be there to help judge that.

Mrs. ROUKEMA. Thank you, Doctor.

Dr. Weber, then Dr. Rubenstein.

Dr. WEBER. I think we have to remember that, for example, in Arkansas, 40 percent, or 40 cents on a dollar, of a hospital bill is to pay for uncompensated care. The majority of the uncompensated care comes from Medicaid and Medicare. I think that we must conquer the uncompensated care problem and the cost-shifting problem. I don't think you can do that without having universal coverage of all Americans.

Mrs. ROUKEMA. Thank you.

Yes, Dr. Rubenstein.

Dr. RUBENSTEIN. A couple of comments, one on saving money in the health care system, of limiting or rationing coverage versus improving how we deliver health care. If we are to look at other service industries, other manufacturing industries, realizing health

care is different, cost savings have come from doing things better and more efficiently, not necessarily doing less of necessary things.

In our experience, there are a lot of management issues where we have saved money without changing the way we give care, as far as the kind of care that is given: shorter hospital stays, different medications, more appropriate management. I would strongly encourage us to look at how we can manage better, rather than how do we ration coverage as a way of saving dollars. And the best way to do that, in our experience, is the intense competition we see in Western Washington, which has forced us to relook at how we use health services and what kind of outcomes we get.

The second comment I would like to make is, as I said earlier, there are market forces that are reshaping health care far quicker than this legislative process. We would much prefer that legislative process tag onto the evolving market forces rather than trying to change them. Specifically, a number of States in this country are trying innovative programs. Certainly, Hawaii has for a number of years. Washington State has passed this legislative reform. Vermont, Florida, and Minnesota.

The Federal Government allowing or enhancing State flexibility, with ERISA waivers or changes—I realize that is a difficult issue——

Mrs. ROUKEMA. It's a sensitive issue on this committee.

Dr. RUBENSTEIN. I understand that. But still and all, the question is whether you want to have one approach nationally, mandated by the Federal Government, or whether you want to allow changes to occur and see how things go over time. It's not a question of whether or not, in my opinion, we need to reform health care. There's a pacing question: How quickly can you do it, given the current social structure?

It is much easier, in the State of Washington or in the Twin Cities of Minnesota, where a lot of these changes already occurred, than it is in some rural areas of the country. That's why I'm not sure you can have this blanket across the country. We would prefer to see a lot of State flexibility.

Chairman WILLIAMS. Although the gentlelady's time has expired, I think Ms. Johnson also wanted to respond, and perhaps others. So if we can get unanimous consent, why don't we extend the gentlelady's time for two minutes.

Mrs. ROUKEMA. Thank you. I think I recognized Dr. Murray, and then Ms. Johnson.

Dr. MURRAY. I think you put your finger on an enormous problem, and it is the enormity of that problem that has led the College of Surgeons to consider the single-payer system as perhaps the best way to get around some of the roadblocks.

Mrs. ROUKEMA. Thank you, Doctor.

Ms. Johnson.

Ms. JOHNSON. Yes. Thank you very much for the opportunity to address this.

I think we are missing a very important piece of the problem related to health care delivery, if we only focus on the access to an insurance card. We live in a society where the focus is on illness and cure, and that is where the largest cost is associated with

health care, instead of a society that focuses on prevention and keeping people well.

We feel very strongly that just providing an individual with an insurance card does not guarantee that they are going to access those primary and preventive services that they so desperately need to stay well and to prevent those kinds of diseases that have them presenting in emergency rooms, in intensive care units, and costing the American taxpayer a lot of money, in terms of returning them to a healthy state.

Mrs. ROUKEMA. Thank you.

Your friend, Mr. Flink, will he have another minute?

Chairman WILLIAMS. Yes.

Mrs. ROUKEMA. Thank you.

Mr. FLINK. Could I just add my two cents worth here? I think the key to controlling costs, which, as we have all said, I think, are driving this process as much as anything, is, in our view, restructuring the delivery system and getting much more towards a coordinated and integrated system of delivering care.

That is a process that we feel Congress should begin and move forward on very quickly this year, because we will not do anything about cost until we get at reducing the duplication of services that are now provided, and restructuring the delivery system can do that.

Thank you.

Mrs. ROUKEMA. Thank you. Your testimony has been very helpful. Thank you very much.

Chairman WILLIAMS. Mr. Payne.

Mr. PAYNE. Thank you very much.

I just have a question for Dr. Duvall. In your testimony you mention that the AMA opposes the intervention of the Federal Government in attempting to have more primary care physicians, with the ratio now being, I think, 7 out of 10 physicians in training intending to move into a specialty. Since you oppose the government trying to force physicians into primary care or as general practitioners, how do you end this trend, which, in another five years, will probably be 8 to 9 out of 10 going into specialization?

Dr. DUVALL. Thank you. That's a very good question. I don't think we know the real answer to this problem, Mr. Payne. It is actually pretty complex, once you start to delve into it. We strongly feel, as you do, that there should be more primary caregivers in a reformed health care system, but to pick a number out of the air that is specific, like 50 or 55 percent, I think presumes a knowledge we really don't have.

Most specialists at this table give an awful lot of primary care, even though they are taking care of cardiology—and I'm sure Dr. Murray gives some primary care. That's one of the things that creates the complexity. We feel that increasing the number of primary care physicians should be a national goal, an ideal toward which we should strive.

Mr. PAYNE. Also, the question of global budgeting, there is opposition to this, and the enforceability of health care cost containment. There is a feeling that this is going to create a problem. Anyone can respond to that. How do we control the escalating costs without having some kind of guidelines?

For example, in New Jersey, when they went to a prospective reimbursement system, the peer review groups got involved, and at the time the length of stay at hospitals was averaging about 9.5 to 10 days. After the hospital rate-setting commission got involved and did prospective reimbursement, we saw the length of stay drop steadily to about 4.5.

Now, without having a regulatory agency say, "You ought to take another look at whether a woman needs to stay in the hospital for nine days for a pregnancy or eight days——" they then looked at trying some other kinds of alternatives, and found that perhaps three or four days might be more than enough. How do you contain costs? Since it has skyrocketed so much, how would it change without some kind of overview, or global budgeting, or somebody pushing you in the right direction, since it has been going in the wrong direction?

Dr. DUVALL. As I mentioned a few moments ago, I think reforming the horizon of health care gives you cost savings in a number of different areas. That same DRG system to which you refer creates the 40 to 50 percent uncompensated care that Dr. Weber referred to in his testimony, which is one of the reasons, I suppose, why we would be a little fearful of a single payer.

There does have to be management and coordination of the Nation's health care financing, as well as the care delivery, but I don't think it has to be done from downtown Washington, DC. The kind of health care targets and analysis of shortfall, continuous quality improvement, in terms of how we are spending our money, I think is going to be very important.

But it's awfully easy to just pick a number, like we're going to inflate 5.15 percent this year, and then to walk away from the problem. There are too many quality issues that that creates for us.

Mr. PAYNE. I agree with you. You know, years ago they used to say, government which governs least is best. But we continually hear about what we really don't like. We're trying to come up with alternatives. How could it be reformed?

As a matter of fact, a number of people have said things are happening around in different States now, and so forth. Two or three years ago that wasn't happening before the Clinton Administration said, "We're going to do something. We're going to do something about health care." I guess this got industry starting to think that there might be some things we could do better. Like you say, we are groping.

Mr. Flink, you mentioned about a reasonable period of time before we could get into sort of universality. What would you consider a reasonable period of time? The only reason I mention this is because I remember in 1954 they said that we ought to integrate schools with deliberate speed, and now here in 1994 the schools in the South are more segregated, as a matter of fact, than they were in 1954. When I see terms like that, I get a little nervous, you know, "a reasonable period of time."

Mr. FLINK. Hospitals, I think, would say the sooner the better. Until there is some system of universal coverage, the cost-shifting, the uncompensated care problems that we have talked about here are going to continue. Just to play that out for a moment, when a hospital, as you, I'm sure, know, has to write off its uncompensated

care or the discounts it takes for serving Medicare and Medicaid patients, that gets passed on to the small businesses who have private insurance.

So, I mean, until we really address that universal coverage issue, we will not have solved the premium cost issue that small businesses and others are complaining about. So, from our perspective, I think the sooner the better. We would welcome it real soon.

Mr. ENGEL. [presiding] The time has expired. I want to give Ms. Woolsey a chance.

Mr. PAYNE. Just one last question—I didn't know the Chairman was going to come, so I was going to take all the time. But since you are taking over the seat——

Just to the nurse, Ms. Johnson, who should pay for this retraining? I see that you emphasize the retraining and dislocation. Do you feel that it is the system that should pay for nurses or health professionals to be retrained, or is this the responsibility of the individual? We are hearing about recertification and education for teachers, should then the educational system pay for all retraining of teachers? Should the system pay for all retraining of paraprofessionals, practical nurses, RNs, et cetera?

Ms. JOHNSON. The President's plan talks about a system that supports the retraining and redeployment. We are talking about 70 percent of a nursing workforce that are now employed in hospitals. While nurses are poised and ready to move the care processes that we provide into the community, there is certainly going to be some enhanced training and some education that is needed.

Certainly, a lot of individuals will be able to take on that responsibility, but a lot will not. We are talking about very, very large numbers. I think it would benefit the communities, and the society as a whole, if the system itself helped support the idea of retraining and reeducating these health care professionals as they move from the hospital and tertiary care into the community where there are more primary, preventive care services that will benefit everyone.

Mr. ENGEL. Ms. Woolsey.

Ms. WOOLSEY. Thank you very much.

First of all, let me apologize for missing most of your testimony. I am one of two Democratic freshmen on the Budget Committee, and, as you know, that is right there at the front of our agenda right now.

One of the reasons it is so important to be there is, one of the major controversies going on on the Budget Committee is whether or not the premiums that businesses and their employees already pay are taxes. So we are going around and around about that. I hope reason is going to prevail and we are going to come to a conclusion that what we already pay is not a tax, it is a premium. And whatever it is called, we need universal health care coverage.

I wanted to respond to Representative Gunderson's confusion about how Dr. Murray's testimony—that I'm sorry I missed, because I probably would have jumped right out of my chair when you said that, with pleasure—that he didn't understand how cost and simplicity and universal coverage could all go together under the single-payer system.

Well, certainly, the single-payer system, I agree with you, is the simplest method for providing health care to this country. And the cost, just with administration alone, the single-payer system costs 3 percent, whereas private plans can cost, for administration only, up to 30 percent of the entire cost. Those are numbers that are pretty straightforward and have been proven. And, of course, the single-payer system provides the universal coverage with provider choice.

Dr. Murray, I concur with you. I concur that the single-payer system is the best method to deliver health care for this country and for our reform. I am sure you have told this before, but will you, because I missed it, talk to us about why universal coverage, not access, but coverage and choice of provider makes such a difference to the provider.

Dr. MURRAY. Well, I think that the issue of cost has become paramount today. And I think that the issue of cost and cost control has inserted itself into the health care system in some ways that are detrimental to the system itself. The patient basically has been eliminated from the stream. He or she no longer makes the decision; it is made by physicians, on the one hand, government on the other, and insurance companies on the third. They find themselves caught in the middle.

We feel that a simplified system, whether it brought the patient perhaps back into the system in a big way or not, is preferable, but if it allows the individual patient to have an open selection of physicians, that at least gives the patient access back into the system in a fashion that is what is missing now from the current system.

Ms. WOOLSEY. Thank you very much. I think what you are saying is, when the consumer and the provider prefer a simplified, straightforward system, then maybe reason will prevail, and maybe our government can provide that to them.

I have one more. Ms. Johnson, bringing delivery services closer to the patient, through nurses and nurse practitioners, will improve delivery and raise the status of nurses, while, I believe, reducing health care costs. And I think you agree with me on that.

Ms. JOHNSON. Yes.

Ms. WOOLSEY. I haven't read all the testimony, and I promise I will. I think you have said there aren't enough nurses to fill those voids, and health practitioners. Do you agree with me on that?

Ms. JOHNSON. Yes.

Ms. WOOLSEY. All right. Then can we bring those training programs to the health facilities, or should they be at community colleges? How do you see this working itself out so it is available, convenient, and current?

Ms. JOHNSON. You have hit on some of the same issues that we talk about, as nurses, about how to do it. One of the things that I think we look at is, there are two pieces that are going to be involved in this.

Certainly, there are some skill enhancements that can take place right within the institutions where the nurses are working. Institutions are looking at new delivery models that take their health care professionals out of the hospital and into the community, providing care to those same patients, and certainly there can be an enhancement of the training programs within those institutions.

On the other hand, there are a lot of nurses who have spent the majority of their time in hospitals that will also need additional education from an academic institution perspective, that talks about health and the fact that it has now moved into the community, and what the new implications are.

In addition to that, there are nurses who want to go even beyond that and look at the issue of providing more of the primary care services. The nurses who are currently in the hospital would need training in academic institutions in order to achieve that particular goal.

So there are two pieces: Certainly, the nurses and the hospitals are working together to look at how some of that skill enhancement can take place within the institutions and then effectively move into the community. But the other important piece is nurses improving their skills from an academic perspective, at the graduate level and beyond, moving out into primary care services as providers.

Ms. WOOLSEY. Thank you very much. Thank you all for being here today.

Mr. ENGEL. Mr. Strickland.

Mr. STRICKLAND. I also would like to thank you for being here and to apologize for missing your testimony. I do promise that I will read your written testimony carefully. I am a little embarrassed, as a Member of this Congress, to know that we do bring individuals like yourselves before us, and then we aren't able to give you the kind of personal attention that many of us would like to. But I do thank you for being here.

I have just a couple of questions. I am wondering if any of you on the panel think that it is possible to achieve universal coverage without either adopting a single-payer system and using some kind of tax mechanism to fund that system or to have an employer mandate. Do any of you envision any other way that we could achieve universal coverage without one of those two approaches?

Yes, sir.

Dr. DUVALL. Well, I think it is possible, in this pluralistic society, to have a blend of mechanisms, and I think some of those you will see in the different legislative thrusts that are on your table and are working their way through these halls.

For example, a health IRA could be an option, a free choice on almost any plan you could conceive of. There are people who are not employed. I think the gentleman from California has referred to the 10 million who probably do have to be covered by a pool plan or an individual mandate. I think it could be set up so that every time someone who is uninsured or unaffiliated checks in to any health care facility, the first thing they do is to get a card. If they can't pay for the coverage they have just, by law, come into contact with, then they will be paid for in the State pool.

So I think there are ways of doing it without federally legislating it for everyone.

Mr. STRICKLAND. I would agree with that. I would take a pluralistic approach also. I think, if you kept Medicare out, as an example, if that is what people chose to do at the present time, but chose to give vouchers to low-income people or businesses that can't afford insurance, and bring them into a State pool, or undo Medicaid

and make a new process and give vouchers to put people through private insurance plans, those would be different techniques.

I think, possibly, putting in legislation that would go in an incremental fashion to answer these problems, so that maybe you hit a 95 percent target now, and 99 percent in a couple years, and then 100 percent coverage in a few years would be a reasonable way to look at it.

Would anyone else like to comment on that?

[No response.]

Mr. STRICKLAND. Dr. Weber, if I could refer to something that you said in your testimony, and I quote, you have said, "A key element of the Academy's plan calls for each person to have a personal physician in one of the generalist specialties." Coming from a large rural district, as I do, where we have problems with numbers of such physician providers, I am wondering if, in your opinion, you think the President's plan goes far enough in addressing the needs of underserved rural areas.

Dr. WEBER. No, I don't think it does.

The rural meeting that was held in Little Rock, Arkansas, actually concluded that managed care would probably not work in all rural areas. Certainly, it has been shown time and time again now that where patients have a personal physician who takes care of maybe 80 or 85 percent of their problems, but, more importantly, directs them through the health care system—a doctor who sees an undifferentiated patient, not diagnosed yet—saves about 30 percent of the cost of the overall system. This is a very important cost-saving part of our plan.

Now, in the rural areas, most of the rural areas have family physicians, about 80 percent of the care in rural America. There are not enough primary care doctors. The Clinton plan has a very specific, mandated government method for reallocating graduate medical education funds and indirect funds that come from the government to correct this problem. I think, probably, it will require something like that to change the behavior and to train enough primary care doctors. I think it does a good job of that, but I think there is still a problem in delivery of health care to the rural areas.

Mr. STRICKLAND. I have one other question. My two closest friends are medical specialists. One is a pediatric surgeon; one is a nephrologist. I respect the kind of training and talent that goes into those kinds of specialty areas, as well as others.

But I have talked with family physicians in my district who are struggling to survive financially, and they talk to me about managing gallbladder problems, or hypertension problems, so on and so forth, working long hours, and their salaries are minuscule compared to some of the salaries of the specialists. And I'm talking about people that I am close friends with.

I have thought, over the last several weeks, how the decision has been made, how it has evolved, that a certain medical treatment or procedure would be worth this level of reimbursement, whereas another procedure would be worth a lesser amount of money. I'm just wondering if any of you—you, especially, Dr. Weber—but anyone else would like to speak to that issue.

Dr. WEBER. Briefly, I would be glad to speak to that. I have served on the resource base relative value study at Harvard, with

Dr. Hsaio, since 1985. Ninety percent of the payments to primary care doctors are for office visits, for evaluation and management services. And these are markedly underpaid.

In almost every one of the 240-some Medicare payment areas in this Nation, the payment for office visits is less than the cost of providing the office visit. That is creating, in rural States and in States like Arkansas, where there are a lot of elderly people, a problem of access to care. And I think they will have to improve the payment for office visits, which are probably the most underpaid.

You are very correct. We did an in-house study. In a nutshell, 40 percent of the family physicians of this country make less than $60,000 a year, which is not enough to pay their debt from education. This has to be corrected as part of health care reform, and we think it will be.

Mr. STRICKLAND. I would echo those sentiments also.

I think that the reimbursement levels, particularly for Medicare, for primary care, are low, and particularly low when you compare them to the reimbursement levels that surgeons are getting. I also think that the reimbursement levels that surgeons are getting and their support for the single payer system comes from their history of reimbursement for Medicare, which I think is out of line.

That reimbursement level—the comparison of reimbursement levels to specialty services, which Medicare is trying to address through the RBRVS, but has not addressed adequately enough to this point in time, has resulted in that differentiation of incomes that you talk about.

Dr. DUVALL. There is another spin I would like to put on this, though. We have talked about the RBRVS, relative value system. In our written testimony, we go into some detail as to how competitive forces can be used with this same basic system, once all the bugs are finally worked out of it.

Specifically, different physicians could have a different conversion factor. That would be publicly known, part of public information. So people could take that into account in choosing a personal physician. Also, health plans, if they were lowballing their premiums because they have physicians with low conversion factors, that kind of information would be known.

One of the things that has been important in maintaining threadbare primary care in very rural areas has been balanced billing. That has been markedly curtailed and is not part of the Clinton plan, for example. But with a variable conversion factor and some balanced billing, if a community really wants to retain their only physician, they could find ways of doing that by their own free choice.

Ms. JOHNSON. I guess I would like to add, Mr. Strickland, that again we are talking about a system that pays a lot more money for you to be sick than to visit a primary care provider and stay well. There are no incentives in a lot of the plans, even at present, to pay for primary care and preventive services that make a difference to persons like Dr. Weber and I.

I think that, again, is something that we have to carefully look at when we are talking about the focus of where payments are. There should be just as much emphasis on the payment, the reim-

bursement associated with keeping an individual well and saving the system down the road as there is just on paying those higher costs that you talked about at the beginning of your statement.

Dr. RUBENSTEIN. I will be quick and echo what many people have said. The emphasis needs not to be on mandating medical schools graduate a certain number of physicians into primary care residencies; the mandate or the direction needs to be how to provide incentives for people who want to go into those specialties, not just physicians, but nurses as well.

I am surprised you didn't comment, but I would like to comment on, as we look at primary care—however we're going to call primary care—as we look at the kinds of services that are given within primary care, we need to look at what percentage needs to be done by doctors versus coordinated by doctors and often done by other professionals who are as well or sometimes better trained than physicians in doing some of those services.

I think, if I were to spend money—and I said this at our State education advisory committee on health care personnel—I would spend the money on doing research on how we ought to be delivering primary care and what are the various approaches to delivering primary care, given the changes in technology, communication, in patient education, and everything else that is available and will be available in the next 10 years.

I am not sure it will always be the typical country doctor approach. There may be a much better and maybe much more efficient way of delivering primary care services, coordinated by doctors, but not necessarily given fully by doctors.

Mr. STRICKLAND. Thank you all very, very much.

Chairman WILLIAMS. [presiding] It is the prerogative of the Chair to open it for a second round of questions. My colleagues may or may not want to join me in taking advantage of a second round.

I want to ask Dr. Rubenstein a question: Your coop is well-known for the commitment that you have brought to provide services to the poor and to underserved communities. As I understand it, that's an HMO; is that correct?

Dr. RUBENSTEIN. Yes.

Chairman WILLIAMS. Many people that have come before the committee have criticized, taken a negative view toward HMOs. Why do you think that is?

Dr. RUBENSTEIN. I think there are some bad HMOs.

Chairman WILLIAMS. What makes a bad HMO?

Dr. RUBENSTEIN. I think there is some bad fee-for-service medicine too.

Chairman WILLIAMS. Sure. Both sides, yes.

Dr. RUBENSTEIN. I think painting a brush across everyone in one portion of this or another is often done without much data and often done through anecdotes. I think that's the reason.

Chairman WILLIAMS. I want to make a couple of comments about things that my colleagues have asked and some of the responses.

First, I want to say to Ms. Johnson, with regard to your comments, Ms. Johnson, that simply giving everybody this or some other card isn't going to get it, that we have to talk about preventive care and this thing that goes under the rubric of wellness. As Chairman, I just want to say, "Amen."

Ms. JOHNSON. Thank you.

Chairman WILLIAMS. I hear that continually, but I hear it almost exclusively from nurses and hospital administrators.

With regard to the question about how do we get to universal coverage, which most of you support, it is true that we could have a pluralistic system. We could have vouchers. We could have savings plans. We could have some alliances. We could allow every State to do it their own way.

But my sense of it is, if we end up in this country, at the end of the day, with the Indian Health Service, the Public Health Service, some kind of Medicaid continuing for the poor, a voucher system, a savings plan system, maybe 50 different systems on top of that in the States, a Veterans Administration system, the American people are going to clear-cut this place and be angry as hell at all of those of you who forced that on them. They want "a" system. I am convinced they want "a," an efficient system.

We have a lot of folks, including, for example, hospital administrators, who come and say, "Get everybody under the tent. Get them under the same tent here. Don't leave the Medicaid hanging out, and the veterans hanging out, and public health hanging out, the Indians hanging out. You're only going to have cost-shifting and duplication and inefficiencies."

So it does seem to me that the more efficient we can get this and the more people we can get in the system, and the fewer different kinds of programs we have, the less bureaucracy we are all going to have to deal with here. And I do think that's what we all ought to be aiming at.

Let me comment briefly on this, because this committee has as its jurisdiction ERISA. There is this matter of the bone marrow case that the gentleman from California, both gentlemen from California spoke of. The courts did not rule that Americans have a right to bone marrow; the courts ruled that that particular insurance policy was denying people what it couldn't deny them, in that particular individual case, and that, in fact, that company provided other people with bone marrow transplants, but was just saying, "Game's over. No more."

That's what the court ruled. It doesn't seem to me it was a ruling that ought to frighten the medical community or the taxpayers of America to say, "Oh, my goodness, we can't make anything off limits." We can, in fact, I think, and the courts have not, to my knowledge, said anything different.

Mr. Flink, let me ask if you would also ask the hospital administrators, either in Montana or here, but perhaps out our way in Montana, to respond to the request of Mr. Gunderson from Wisconsin, with regard to the antitrust provisions. It would be helpful to us if a couple of you were providing us with your recommendations. So we would appreciate receiving those.

Mr. FLINK. We would be eager to do that.

Chairman WILLIAMS. Thank you.

With regard to the CBO and the matter that was raised by one or maybe a couple of my colleagues, and that is, the President's plan is extraordinarily more costly than he had first envisioned, we have spent some time on this committee, in the last 24 hours, looking closely at what the Congressional Budget Office actually testi-

fied on. We are going to go over it some more, and we are going to go down and talk to them, as well, and have them come up.

It appears what they are saying is, "Mr. President, you underestimated what the subsidy to small business will cost the American people." That appears to be what they are saying. In fact, as I understand it—I wasn't there—as I understand it, in questions of Mr. Reischauer, he said, yes, that's the problem, that the 3.5 percent cap on small business, in order to protect them, is going to cause a huge subsidy from the American public, up to the year 2003, which is six years after the plan goes into effect.

So Reischauer is saying, for those first few years, the plan is more expensive. Then he says the President is right thereafter, and both during those years and in the out years, the President is correct about the reduction in health care costs in America. So there was some bad news and some good news, it seems to me, in what was said.

Finally, I want to comment on this matter of just covering the uninsured. A couple of people have suggested, both on this panel and previously, that, "Well, if we've got 37 million uninsured, just cover the uninsured." If we do that, we don't solve all of the problems, but we do start to move to universal coverage, providing we say to employers who now offer their employees insurance, "You cannot make your employees uninsured. You're locked. You've got to continue to offer them insurance."

If the taxpayer is only going to insure these 37 million out here now, no employer can drop their insurance. Otherwise, what are you going to have? Cost-shifting to the public. I mean, is there anybody here that doesn't believe that employers would say, "Wait a minute. I can get a free ride on this. I can get rid of this 16 percent of my payroll costs that health care is now costing me. I'll just shift that to the taxpayer." Of course, that's what would happen.

So it's not that easy.

Any others?

Ms. Woolsey, would you like additional time?

Ms. WOOLSEY. No, thank you.

Chairman WILLIAMS. Mr. Strickland, how about you?

Mr. STRICKLAND. I just would like to make a statement to these persons.

I have traveled throughout my district. I visited 14 hospitals, multiple clinics. I have talked to physicians and nurses and other health care providers. And I have been so impressed at the attitude of the professional community. Hospital administrators that I have talked to in my district want health care reform. Surprising to me, in a sense, physicians have expressed to me, not universally, but most physicians have expressed to me, they want health care reform. They know that there need to be positive changes made.

In months past, when I thought about this effort and what we, as a Congress, were likely to face, I assumed, I think, incorrectly, that the provider community would not be allies. Although we don't agree, obviously, about a lot of things, and some of you don't agree about a lot of things, I think there is great support among the provider community to make our system better.

I think there are other forces involved in this process that are not as committed to positive change and committed to patient care.

But I just really feel encouraged, based on my own personal interaction with the provider community, and I want to thank you for that. I thank you for being here.

Thank you, Mr. Chairman, for allowing me to participate, although I am not a member of this subcommittee.

Chairman WILLIAMS. The Chair would add another "Amen" to what the gentleman has said about the provider community.

Ms. Woolsey.

Ms. WOOLSEY. I should have said this before I said I didn't want to say anything more.

In my district, I have had 10 health care forums, throughout my entire district. In fact, we had one on a Saturday night, at 7 p.m., at one of our universities, and there were over 100 members of the public there. That just goes to show the interest.

What I have come out with is that—first of all, I had a member of the President's plan presenting that and somebody presenting the single-payer system. What the people in my district—and I don't think we're too different from most of the country—want is simplicity, cost-effectiveness, universal coverage, and they are willing to step up for some additional expenses, as long as they get real health care reform.

I hear from the doctors in my district, and the hospitals, that they want to work with us, and they, too, have the same goals. So, again, thank you.

Chairman WILLIAMS. We have had a lot of panelists before us, and we haven't had any of them more helpful than you have been. We really appreciate it. One of the things that you have shown us again is, there is great diversity of belief, even among physicians and hospital administrators, nurses, people who work on the front lines with this. But knowing that diversity is helpful. It doesn't compound or confuse our problems; it, in fact, helps us.

We are very, very grateful, particularly to those of you who traveled a long distance to be with us. Thanks very much.

The hearing is adjourned.

[Whereupon, at 12:55, the subcommittee was adjourned, subject to the call of the Chair.]

[Additional material submitted for the record follows.]

National Diabetes Advisory Board

1801 Rockville Pike, Suite 500
Rockville, Maryland 20852
(301) 496-6045

January 21, 1994

The Honorable Jon Weintraub
U.S. House of Representatives
Washington, DC 20515

Dear Representative Weintraub:

Adopting the recommendations from this letter can save $20-30 billion annually in health care costs while saving thousands of lives and improving productivity and quality of life.

The National Diabetes Advisory Board was established in 1976 (P.L. 94-562) and was given a mandate to advise and make recommendations to Congress, the Secretary of Health and Human Services, and appropriate federal agencies regarding diabetes research and treatment activities. This letter is written in accordance with our statutory mandate.

A just completed 10 year national research study on the control and complications of diabetes (Diabetes Control and Complications Trial, summary attached) shows beyond a shadow of a doubt that relatively easy and simple-to-accomplish *intensive management* can greatly reduce or substantially delay complications from the disease. The preventive approach requires the use of affordable measures - frequent blood glucose monitoring and insulin injections combined with education of patients in self-management and periodic visits to diabetes treatment teams.

The problem is that these measures are for the most part inadequately covered by insurance. The cost of the economically and socially justified preventive approach is minimal when compared to the billions being spent annually in the U.S. on the treatment of complications from diabetes. Savings would result by not having to spend money on unnecessary kidney disease and dialysis, progressive eye disease that may end in blindness, amputations and numerous other complications *that can be delayed or even prevented* if coverage for inexpensive preventive measures is included in health care reform legislation to be considered by the Congress this year.

What we specifically propose is that supplies (blood glucose meters and test strips, insulin and syringes) and an integrated approach to treatment that is oriented to prevention *of complications* (regular visits to diabetes educators, nutrition specialists, endocrinologists, ophthalmologists, podiatrists) be included *as reimbursable* items in any future health care legislation.

The health care reform efforts of President Clinton, and the principles upon which his proposed legislation is based, are supportive of the Board's recommendations. These principles, including universal access, community-based rating and inclusion of pre-existing conditions, when combined with the preventive approach to complications from diabetes outlined below, will benefit all of society. Therefore, the Board supports the Administration's health care reform proposal.

Simply stated, access to, and coverage of, preventive measures will improve the lives of the 13 million people with the disease, and save the country billions of dollars in health care costs. It is incumbent upon legislative and executive leaders to seize a rare opportunity to improve life and save dollars, an opportunity created by your previous wise investment in diabetes research.

I have enclosed more detailed materials for your information and would appreciate the opportunity to testify before relevant committees to explain the significance of our recommendations. I and our staff also would be pleased to suggest language that could be included in specific health care reform legislation and regulations. Thank you for your interest. We look forward to your response to our proposal and our request to testify. We would be pleased to work with you at this critical juncture for the country's health care system.

Sincerely,

Saul Genuth, M.D.
Chair, National Diabetes Advisory Board

Enclosures:

Diabetes Control and Complications Trial Summary
Roster of Board Members

DIABETES CONTROL AND COMPLICATIONS TRIAL AND HEALTH CARE REFORM

1993 is a year of singular importance for diabetes mellitus. The conjunction of two pivotal events has opened a window of opportunity that allows a major step forward in the care of this disease. The first event was the completion in June 1993 of the Diabetes Control and Complications Trial (DCCT). The conclusive results of the trial - described below - are attributable to the foresight of Congress; to the wisdom, detailed study, planning and organization of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK); and to the outstanding dedication and performance of over six hundred investigators and fourteen hundred patient participants.

The DCCT is exemplary of what can be accomplished by a combination of enlightened legislative policy, a well-directed biomedical research program and well-executed clinical research. The DCCT has clearly set a new Standard of Care for diabetes.

The second major event is the joint health care reform initiative of the Administration and Congress with its emphasis on prevention and cost effective medical care. By applying the results and lessons of the DCCT to a plan for reshaping our health care system, thirteen million patients with diabetes can directly benefit. At the same time, diabetes and its management during the next decade can serve as a unique role model for how the health care system should approach all chronic diseases.

In 1974, Congress approved legislation (The National Diabetes Mellitus Research and Education Act, Public Law 93-354) that provided for the formulation of a long-range plan to combat diabetes and its complications. The resultant plan developed by the National Commission on Diabetes called for a national clinical trial to determine whether the late developing and devastating complications of diabetes (blindness, kidney failure, amputations, heart attacks) that eventually affect 80-90% of the patients in some form or other can be greatly reduced by better control of blood glucose (sugar) levels. If so, could this be accomplished by available management techniques? The NIDDK carefully studied the issue and concluded in 1981 that the time was ripe to answer this question in a definitive manner. Congress provided the necessary financial support, and in 1982, the DCCT was initiated. Fourteen hundred forty-one volunteers with insulin dependent diabetes were in twenty-nine clinical centers and randomly assigned to receive either excellent conventional treatment or intensive "full court press" treatment. The latter treatment was intended to lower blood glucose levels to as close to normal as safely possible.

Each diabetes complication was carefully measured for up to nine years. In June 1993, the results became crystal clear.

- Intensive treatment decreased by 50-75% the development of diabetic retinopathy (eye complications), nephropathy (kidney complications)

and neuropathy (nerve complications).

- Intensive treatment was associated with a reduction in heart attacks and other events caused by atherosclerosis (hardening of the arteries).

- Ninety percent of patients who received intensive treatment were able to greatly improve their blood glucose levels and 50% of the patients approached normal levels.

- When trained, motivated and supported by a qualified health care team, the intensively treated patients could become expert at day-to-day self-management.

The success of intensive treatment depended critically on providing patients with adequate access to qualified nurses, dieticians, diabetes educators and mental health professionals as well as physicians. The patients also needed ample supplies to test their blood glucose and inject insulin three or more times per day.

Since the announcement of the DCCT results, the National Diabetes Advisory Board (NDAB) has addressed the issue of their applicability. Can these results be translated into clinical practice in the daily care of millions of Americans? What would be the public health benefits? What professional and financial impediments exist to translation of these results within the current health care system? How might these impediments be overcome within the context of the current health care reform initiative?

In seeking answers to these questions, the NDAB has obtained input from numerous sources. The Board has found that all the major conclusions of the DCCT have been accepted without challenge by the medical scientific community. The resulting new Standards of Care are rapidly being disseminated to physicians, nurses and dieticians across the country in writing and in continuing education forums. The response of the health care professionals has been very positive but the need for enhanced resources with which to translate the DCCT findings into daily practice has also been emphasized. In a thorough study of translation issues, commissioned by the NIDDK (Metabolic Control Matters), an expert group concluded:

1. That better control of blood glucose would benefit all persons with diabetes. This includes both patients with insulin dependent diabetes who were specifically studied in the DCCT, as well as the much more numerous patients with non-insulin dependent diabetes.

2. That the goal of normal or near normal blood glucose should be the Standard of Care for treatment of diabetes mellitus.

3. That professional curricula should include the principles of intensive insulin management of insulin-dependent diabetes with normal blood glucose as a

goal.

4. That other methods appropriate to treatment of non-insulin dependent diabetes should also be vigorously employed in those patients with normal blood glucose as a goal.

5. That a National Diabetes Education Program should be established to inform patients, professionals and the general public of the importance of lowering blood glucose levels. Furthermore, all relevant government and voluntary health agencies should collaborate in such a program.

6. That training patients in the skills of self-management is a critical tool for maintaining blood glucose levels close to normal.

7. That health care financing policy should eliminate current barriers to implementation, especially inadequate reimbursement for supplies and for professional services aimed at training patients in self-management.

The NDAB strongly endorses all of these conclusions.

The economic realities that bear on translation of the DCCT result were also reviewed by the NDAB.

1. A 1992 survey has shown that patients with diabetes generate 15 percent of the total health care cost of all Americans. Of approximately 700 billion dollars spent on health care in 1992, it has been estimated that about 100 billion was spent by people with diabetes for treatment of their disease and other medical problems. In accord with that estimate, health care expenditures by persons with diabetes were more than three fold higher than for the general public ($9500 per patient per year vs. $2,600). This difference was irrespective of age. Compared to the general population, people with diabetes spent a greater proportion of their health care dollars on inpatient hospitalizations, drugs and home health care costs. <u>These increased costs are caused by eye, kidney, nerve, and atherosclerotic complications which we now know can be markedly reduced.</u>

   Some patterns of health care expenditures related to diabetes were seen to be contrary to the goal of preventing complications. Compared to the general public, persons with diabetes spent a lower percentage of their health care dollars on out-patient visits, even though such visits are preventive in nature if used to maintain blood glucose levels. Employers paid for a lower percentage of the health care costs of persons with diabetes than of other people. Yet the less access to care that such patterns suggest, the more persons with diabetes ultimately cost the health care system. Therefore, large savings could be

realized if health care reform permitted the DCCT results to be translated broadly and better control of blood glucose were achieved in all patients with diabetes.

2. Intensive treatment aimed at lowering blood glucose to normal cost approximately $2,000 more per year than conventional treatment. Most of this difference is attributed to increased outpatient care largely rendered by non-physician health personnel and more use of supplies. In contrast, hospitalization costs are not significantly increased. This figure must be compared to the future savings that would result if blindness ($12,000 per patient; there are approximately 24,000 new cases each year. The annual cost of diabetic retinopathy is approximately $500 million per year); kidney failure ($40,000 per patient; $ 1 1/2 billion per year); and amputations ($10,000 per patient; $1 billion per year) were prevented.

3. Private sector charges by diabetes treatment centers providing initial comprehensive diabetes training programs are in the neighborhood of $750-$1,000 per patient. Charges for physician and laboratory services are usually reasonably well covered but the costs for training in self-management by nurses and dieticians are usually either poorly covered or not reimbursed at all. Coverage by Medicare and Medicaid has been inadequate. For example, Medicare covers the cost for blood glucose testing for patients who use insulin, but does not cover insulin syringes. Patient training self-management is reimbursable only if incident to a physician's service, a provision which usually means that such services are not provided. Medicaid coverage is inconsistent and varies from state to state.

4. Managed care until now has generally limited access of patients to excellent diabetes treatment for a number of reasons. Gatekeepers are not motivated by the potential of long-term benefits to refer patients for intensified management. Preventive services and supplies are less likely to be covered under administrative policies which aim to minimize expenses. Even with risk adjustment, diabetes patients receive the highest community ratings for health care. Health care marketing is shunted away from patients with diabetes. Laboratory services are often limited by capitation so that the necessary tests such as glycosolated hemoglobin are done far too infrequently. HMO and other contracts typically change every year or two and change of employment causes further disruption so that diabetes care is often inconsistent in its coverage and its application.

   Managed care, however, as envisioned by the Administration's health care reform proposals, importantly also holds the potential for major improvement in diabetes care. Accountable managed care could decrease excessive utilization of services for people without diabetes which are not well justified

medically and shift the resulting savings to pay for cost effective preventive care for patients with diabetes. Managed care could also replace the currently fragmented unsystematic approach to delivery of diabetes care with a well ordered system. In that regard, Congress should encourage and support outcomes research to determine the best models for delivery of such care. In any good model of managed diabetes care, however, patient should be assigned to receive the level of care they need to achieve as normal a blood glucose as possible. This could be based on the type of diabetes, on difficulty in achieving satisfactory control of blood glucose, on the presence of complications or on other pertinent factors. Such models should encompass the services of primary care physicians, of specialized diabetes treatment teams, and of both these types of medical resources working in collaboration. Managed diabetes care should make these services available as needed.

When the DCCT results are considered in light of the current health care reform initiative, it is apparent that better treatment of diabetes and the goals of health care reform are synonymous. The goals proposed by the Administration's plan include universal access to care, comprehensive coverage of prescriptions, an increase in primary care and preventive services, and an increased role for non-physician providers. All Americans with diabetes need unlimited access to medical insurance in order to lower blood glucose levels consistently and thereby prevent the physical and economic burdens of future devastating complications. They need complete insurance coverage for insulin, syringes, oral blood glucose lowering drugs and other medications. They need access to primary care physicians and diabetes specialists (individually or in efficient shared care arrangements) who are reimbursed adequately enough to give the proper time required for guiding the management of blood glucose and for monitoring diabetic complications at each visit. They need blood glucose meters and test strips for management purposes. Most importantly, they need insurance coverage for ample services from nurses, dietitians, social workers and mental health professionals who will play a dominant role in providing them skills in self-management of blood glucose, thus helping to maintain normal blood glucose levels, prevent complications and thereby reduce the huge physical and financial burden these complications create.

In order to fulfill the above needs of people with diabetes, the NDAB supports the Administration's proposed health care reform plan. The NDAB recommends in the strongest possible terms that within the Health Care Reform Act, Congress make specific provisions that will guarantee the preventive services described above to patients with diabetes. In so doing, Congress will have the unusual opportunity to close the circle it began in 1974 by appropriating funds that initially led to support of the DCCT from 1982 to 1993 and that now can guarantee the very treatment that research has proven to be so beneficial.

1/4/94

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**STATEMENT OF THE
AMERICAN ASSOCIATION OF
OCCUPATIONAL HEALTH NURSES**

**PRESENTED TO
THE HOUSE EDUCATION AND LABOR
SUBCOMMITTEE ON LABOR MANAGEMENT RELATIONS
JANUARY 14, 1993**

INTRODUCTION

The American Association of Occupational Health Nurses (AAOHN) is the professional association for over 12,000 registered nurses who provide health and safety services at the worksite. Over 22,000 occupational health nurses work in large and small businesses across the country. More than 60 percent of AAOHN members are the only health care provider at their workplace.

Occupational health nurses provide a wide array of comprehensive health and safety services for workers and their families. The primary focus of our work is on preventing illnesses and injuries. Worksite-based nurses are responsible for:

- delivering primary care for occupational and non-occupational illnesses and injuries,
- ensuring compliance with laws and regulations governing occupational health and safety,
- assessing worksite health hazard exposures and operating necessary worker health surveillance programs,
- investigating, monitoring and analyzing illness and injury episodes and trends and developing work procedures and training programs to control workplace hazards,
- conducting health promotion and illness and injury prevention programs,
- managing workers' compensation cases to facilitate return of ill or injured workers to productive work in a cost-effective timely manner,
- designing and implementing worksite accommodations for disabled workers, and

- administering occupational health and safety services and supervising health and safety program planning, policy development, benefit design, and cost control initiatives.

Our Association and its members are extremely concerned because many of the health care reform plans under consideration eliminate or substantially reduce employer incentives for worksite health and safety programs.

ROLE OF OCCUPATIONAL HEALTH NURSING IN PROMOTING WORKSITE HEALTH PROGRAMS

Worksite health and safety programs have become a positive, cost-effective component of our nation's health care system. Under the current health care financing system, responsible employers who provide health insurance for their employees have been able to decrease their costs by sponsoring successful wellness programs.

A recent comprehensive review assessing the impact of worksite health promotion programs concluded that such programs can reduce annual health care costs per employee by as much as $865. J. Opatz, D. Chenoweth, and R.L. Kaman, Economic Impact of Worksite Health Promotion, Association for Worksite Health Promotion Publications, 1990, Northbrook, IL. It is, therefore, not surprising that 81% of private worksites with 50 or more employees now offer some form of health promotion activity. U.S. Public Health Service, National Survey of Worksite Health Promotion Activities Final Report, p 30 (1992). Nor is it surprising that self-insured worksites are more likely to offer on-site wellness programs than are worksites that are insured through an insurance company. Id.

Worksite health promotion is a particularly effective way to reduce spiraling employee health care costs in today's fast-paced society. See K. R. Pelletier, A Review and Analysis of the Health and Cost-Effectiveness Outcome Studies of Comprehensive Health Promotion and Disease Prevention Programs, 5 Am. J. Health Promotion (1991). The worksite provides a convenient setting for employees and it offers the peer support that many people need to sustain healthy habits. With its captive audience of a broad cross-section of people, the worksite also provides a way to reach high-risk workers who are not likely to participate in community-based programs.

The broad scope and effectiveness of these programs has been documented by many individual companies and AAOHN members. The American Telephone and Telegraph Company estimates it avoids $1.60 in medical costs for every $1.00 it spends on health

promotion activities such as smoking cessation, exercise and nutrition counseling. Big Companies See Health Costs Slowing, Wall St. J., Oct. 22, 1993, at A2.

In response to a June 1993 survey of AAOHN members, one occupational health nurse, who provides health care to hospital employees, described the scope of her practice, saying:

> We have a broad scope employee health program and work closely with the in-house employee assistance program, as well as the employee wellness program. (We are all part of human resources and work as a team.) Safety is closely integrated. All statistics are shared and interventions are planned and implemented with all departments involved. Employee health provides pre-placement and annual health screens, immunizations, drug screening, follow up for exposures to communicable disease, blood exposure management, return to work clearance, workers' compensation treatment/case management, respiratory protection and hearing conservation programs and health counseling and referrals for employees.

Another AAOHN member, who works for a light manufacturing company with 800 employees, reported that her company's occupational health service provides on-site primary care, on-site treatment of illnesses and injuries, return to work/modified work programs, worksite hazard analysis services (safety programs, job analyses, environmental monitoring, audiometry, spirometry, etc.), health surveillance, health promotion/wellness programs, health education for employees and their families, counseling, substance abuse prevention, disability management and case management. Furthermore, this nurse noted that, by implementing this comprehensive worksite-based program, her employer reduced its health care costs approximately $200,000 in one year.

HEALTH REFORM LEGISLATION MAY SUBSTANTIALLY REDUCE EMPLOYER INCENTIVES FOR WORKSITE HEALTH AND SAFETY PROGRAMS

AAOHN is deeply concerned that many proposals for restructuring the nation's health care system will substantially erode worksite health and safety programs by:

- eliminating many of the incentives for operating such programs, or even worse, by
- creating disincentives for the employers who sponsor or the employees who participate in the programs.

Employers paying a community-rated premium or a fixed percentage payroll tax will have little financial incentive to invest in health and safety promotion programs. Even if these programs are successful, they will have no effect on employers' health care costs under health reform plans requiring an employer to pay a fixed premium per worker. Moreover, employers may be reluctant to offer health promotion and injury and illness prevention activities if the programs cease to be tax deductible business expenses. Worse yet, health reform plans that tax employers or employees for benefits that exceed those in a standard benefits package could create disincentives for offering and/or participating in health promotion activities that would be considered taxable income.

Managed competition models for reform also impose structural impediments to worksite care. When employees at a worksite are served by many different health plans, no one plan will have enough presence to justify the expenditures necessary to provide on-site services. AAOHN believes this situation will result in fragmented care, longer periods for return to work, and increased direct and indirect (decreased productivity and quality, increased training for replacement employees, etc.) costs.

RECOMMENDATIONS

To maintain worksite health and safety initiatives such as the ones described above and to encourage establishment of similar programs in other companies, health reform should offer financial incentives to employers who operate worksite health and safety programs. Depending on how the health care delivery system is restructured, employers who provide qualified programs could receive a discount in the premium or the tax they pay for employee health benefits or they could be allowed a tax credit for the costs of their programs.

Health reform provisions that limit the tax deductibility of health benefits that go beyond the scope of the basic coverage package should be carefully drafted. Unless the legislation expressly excludes worksite health and safety programs from the definition of a health care benefit, the taxes will create a disincentive for worksite initiatives.

AAOHN also recommends that Congress supplement provisions designed to encourage worksite health and safety promotion included in its health care reform legislation with program elements in OSH Act reform having the same objective. For example, OSHA reform could include incentives, such as a tax credit for meeting or exceeding a particular safety index or a reduction in inspection frequency tied to employee training

initiatives, to spur implementation and continued operation of comprehensive worksite health and safety programs.

CONCLUSION

In summary, AAOHN firmly believes that health care reform should provide universal access to high-quality, cost-effective health care which emphasizes health promotion and illness and injury prevention. To be most effective, care should be available where people live and work. Employers and health professionals, recognizing the importance of these principles, are already achieving these goals through worksite health and safety programs. The Association urges Congress to adopt health care reform legislation that provides meaningful financial incentives for implementing and operating effective worksite health and safety programs in companies of all sizes. Such programs are crucial to the design of a health care delivery system with a high potential for cost savings because those programs focus most effectively on preventing illness and injury.

THE AMERICAN LUNG ASSOCIATION AND THE AMERICAN THORACIC SOCIETY

These comments are submitted on behalf of the American Lung Association and its medical section, the American Thoracic Society.

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society -- a 10,000 member professional organization of physicians, scientists, and other health professionals specializing in pulmonary medicine and lung research -- the American Lung Association provides programs of education, community services, advocacy and research to fight lung disease and promote lung health.

Every year, nearly 310,000 Americans die of lung disease. Lung disease is now America's number three killer, responsible for one in seven deaths. That rank will likely change. The lung disease death rate is climbing steeply, while the rates for America's first-and second-ranked causes of death, heart disease and cancer (except for lung cancer), are dropping. From 1979 to 1990, the lung-disease death rate rose by 20.6 percent, while the death rate from heart disease fell a dramatic 23.8 percent.

A little over three years ago, and in part because of these grim statistics, the ALA/ATS began deliberating the issue of health care reform, looking at the issue from the unique perspective of the needs of people with chronic lung disease. In 1992, we formalized our thoughts in a policy statement that was approved by the respective Boards of Directors of the two organizations. A copy of our policy statement is included with this testimony. We support guaranteed coverage that prohibits any pre-existing condition exemption. The coverage must be portable and affordable as well. Our statement also specifically endorses continuation of an employer-based system that mandates employer participation with mechanisms to facilitate that participation.

EMPLOYER MANDATE

The ALA/ATS believes any new health care system should be built upon our current public/private system. We support an employer-mandated system in which mechanisms and incentives are established to help employers finance health care benefits for their employees and the employees' dependents. Our statement proposes a list of benefits the ALA/ATS believes must, at a minimum, be included. Employers would certainly be free to offer benefits above and beyond those mandated. Individuals also would be allowed to purchase supplemental coverage on their own if they so choose.

In the past forty years, Americans have come to rely on their employer as the provider of health insurance. While the Clinton plan does not mandate that the employer choose the one or two plans to be offered to their employees, it does require the employer to serve as the chief or primary contact for the employee to deal with the overwhelming and daunting health insurance

system. Workers already are comfortable with that arrangement. The role of the employer certainly changes under the Clinton plan from that of benefits administrator, to more of a facilitator of information. It appears this would be a less time-consuming and less costly role for the employer, while retaining the current relationship with the employee. Individuals who are uncomfortable obtaining health insurance through their employer have the option to work directly with the regional health alliance.

The ALA/ATS does not believe that the health care system should be financed totally by either the government or the private sector. But rather, the current sharing of responsibility is the appropriate way to proceed. Based on that belief, the proposal for employers to finance partial coverage, with assistance from the government, is ideal. This arrangement does not preclude individual responsibility for paying for a part of his or her health care costs.

BENEFITS PACKAGE

Our statement also provides details of what we believe a standard benefits package should look like, giving examples of pulmonary-specific benefits. A chart detailing that discussion is located on page 3 of our attached policy statement.

The ALA/ATS supports a uniform package of basic benefits that includes the appropriate levels of preventive, acute, chronic, and rehabilitative care. Although we do not specifically include long-term care benefits in our position paper, we also would support the inclusion of long-term care benefits in a basic package.

INSURANCE REFORMS

The ALA/ATS supports the need for changes in our current health insurance industry to ensure universal access to care. Most of these changes are included in the Clinton proposal. Primarily, all pre-existing condition clauses or mandated waiting periods must be eliminated. For people with chronic conditions, even a six-month delay in coverage could be catastrophic. If the particular treatment is expensive, the person may become bankrupt in the intervening time, or forego the expensive treatment, thereby increasing the severity of their condition -- and in all likelihood the ultimate cost of treating their illness -- for when they do become eligible for coverage.

The ALA/ATS believes that coverage must be guaranteed renewable and that coverage should not be cancelled for any reason, including nonpayment of premiums. Although every effort should be made to ensure that individuals who can afford to pay for their treatment do so, inability to pay for care must not be the deciding factor in care delivery.

Community rating must also be ensured. People who are sick must have access to the health care system. Charging them more to receive the benefits they need -- which, in fact, the current premium system does -- is inherently wrong. This approach must be changed to a system that treats everyone equally. Many diseases, conditions, or injuries are unavoidable and people should not be penalized for becoming ill or disabled.

The ALA/ATS also supports the consolidation of the medical portion of the worker's compensation plan into the new system. This program has created jurisdictional problems from both an insurance perspective and a health care management perspective; we welcome the president's proposal in this area.

CONSOLIDATION OF FEDERAL HEALTH PROGRAMS

The ALA/ATS supports the president's proposal to consolidate the Federal Employees Health Benefits program and the Medicaid program into the new system. We also support the consolidation of all other federally funded health programs into a single entity. We would include in this consolidation programs currently funded through the Veterans Administration, the Department of Defense, the Indian Health Service, the migrant health centers, and so forth. We believe this would eliminate costly duplication of physical structures, equipment purchases, and personnel. This consolidation would also stream-line government functions. Instead of having multiple rules, regulations, and procedures -- not to mention forms -- one single procedure could be used by all federal health systems.

COMPREHENSIVE SCHOOL HEALTH EDUCATION

The ALA/ATS also believes that comprehensive school health education is necessary for instilling positive health habits in our children. Such a program should include information on health-risk behaviors such as tobacco use and drug abuse, environmental health concerns, personal health, nutrition, and the prevention and control of diseases. The ALA/ATS already has several school-based programs in place, including our "Open Airways for Schools" program that focuses on

asthma education and self-management, and our Smoke Free Class of 2000 project that teaches students about the health dangers of tobacco use.

SUMMARY

In summary, the ALA/ATS supports a mandate on employers to help finance health care benefits for their employees and the employees' dependents. The system must include mechanisms that allow and ensure compliance with this mandate. The benefits provided by the employer must be comprehensive and uniform for all individuals, with the option for either the employer or the employee to purchase supplemental benefits. The ALA/ATS also supports changes to the current system to eliminate cherry picking and other cost avoidance mechanisms used by the health insurance industry. The ALA/ATS also believes that health education must be recognized as an important and integral component of our educational system.

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AMERICAN THORACIC SOCIETY

AMERICAN LUNG ASSOCIATION®

Position Statement of the ALA/ATS Health Care Policy Task Force

REFORM OF THE U.S. HEALTH CARE SYSTEM

Prepared by the American Lung Association and its medical section, the American Thoracic Society

When You Can't Breathe, Nothing Else Matters®

Founded in 1904, the American Lung Association includes affiliated associations throughout the U.S., and a medical section, the American Thoracic Society.

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American Review of Respiratory Disease

American Journal of Respiratory Cell and Molecular Biology

Adopted by ATS Board of Directors November 13, 1992

Adopted by ALA Board of Directors December 12, 1992

Position Statement of the ALA/ATS Health Care Policy Task Force

REFORM OF THE U.S. HEALTH CARE SYSTEM

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society -- a 10,000 member professional organization of physicians, scientists, and other health professionals specializing in pulmonary medicine and lung research -- the Lung Association provides programs of education, community service, advocacy and research to fight lung disease and promote lung health.

Based on this mission, we believe our health care system must meet the multiple needs of people with lung disease. It is widely recognized that far too many people are without access to even the most basic of health care services in our current health care system. This structure, therefore, does not meet the needs of people with lung disease or other diseases existing in our society today.

A strong national medical research agenda as well as an effective medical education program are critical to our health care system. However, after considerable discussion, the Task Force agreed that this document was not the proper place to consider these significant yet slightly tangential issues.

The ALA/ATS believes that patients (consumers of health care) and deliverers of health care must have an effective voice in the health care reform debate. As advocates for persons with lung disease and representing people who deliver health care, we therefore call on Congress and the federal government to enact comprehensive health reform that takes into account the principles outlined in this document. We recognize the complexity involved in these proposed changes and the need for a structure to represent the diverse constituencies to implement the changes.

ALA/ATS POSITION STATEMENT ON HEALTH CARE POLICY

The ALA/ATS supports the development of a health care system that will meet the special needs of patients with lung disease based on the following criteria:

ELIGIBILITY

ALA/ATS POSITION: Health care is a right. Our health care system(s) must guarantee access to a basic level of services for all residents of the United States regardless of employment status, ability to pay, pre-existing condition or other factors such as, but not limited to, age, gender, sexual orientation, or racial or ethnic background.

We believe health care is a right to which individuals are entitled by virtue of their existence. We recognize and separate this right from those rights that are guaranteed through the Constitution of the United States and the legal system of the United States. Residents of this nation must not be excluded from the health care system for any reason.

Although we believe all U.S. residents must have access to the health care system, we recognize that parameters must be set with regard to the breadth of services provided. For that reason, we support a basic level of health care services to which all residents are entitled. Unfortunately, the United States simply does not have the resources to guarantee unlimited health care coverage to all individuals.

COVERAGE AND BENEFITS

ALA/ATS POSITION: Comprehensiveness – The basic level of services must be the same for all individuals. These services include appropriate levels of preventive, acute, chronic, and rehabilitative care, and must be provided so as to preserve continuity of care. Access to these services must continue regardless of the cause of illness, or an individual's employment, physical, mental, geographic, or financial state.

ALA/ATS POSITION: Quality of Care – The basic level of services should be effective, appropriate, and timely. Medical effectiveness is defined by research findings. Appropriateness is determined by the patient, the family, and the health care team. Timely means without delays that would otherwise adversely affect the outcomes of care.

ALA/ATS POSITION: Basic Level of Services – These services should be broad-based and the same for all individuals. Services to be provided are listed on the following page.

BASIC HEALTH CARE SERVICES TO BE PROVIDED

	Basic Health Services	Pulmonary-Specific Examples
Preventive	Prenatal care Well baby/well child Family planning services Childhood immunizations Adult immunizations Education Periodic health examinations Effective therapies for at-risk populations	TB skin test Appropriate testing for congenital processes (cystic fibrosis, alpha-1 antitrypsin deficiency) TB prophylaxis Influenza, pneumococcal vaccine Smoking cessation programs Pentamidine aerosol (HIV) Screening for occupation- and environment-related pulmonary problems Routine and complaint-specific clinical evaluations
Outpatient	Diagnostic evaluation: history, physical examination, testing, procedures, chronic therapy Prescription drugs	Diagnostic evaluation: routine physical problem-directed history, physical examination Diagnostic testing: radiologic imaging, pulmonary functions Outpatient procedures: thoracentesis, fiberoptic bronchoscopy Ongoing treatment for chronic problems: chronic obstructive pulmonary disease -- COPD (chronic bronchitis, emphysema), cystic fibrosis, sarcoidosis, asthma, occupational lung diseases
Inpatient	Extensive diagnostic evaluation Complex treatment of both acute and chronic conditions	Follow-up for positive findings on diagnostic evaluation Treatment for serious exacerbation of chronic problem(s): COPD Treatment for serious exacerbation of acute problems: pneumonia
Rehabilitation	Physical therapy Occupational therapy Supportive care: nursing facilities, home care, durable medical equipment, respite, hospice Mental health services: substance abuse	Physical therapy Occupational therapy Respiratory therapy Pulmonary rehabilitation Supportive care: home care, chronic ventilator care, oxygen

We believe all societal barriers must be eliminated, including jurisdictional questions over coverage, so all individuals have access to the same, uniform set of services and that these services are portable. The guaranteed services should span the continuum of coverage from preventive health services including prenatal and pregnancy care, immunizations, and health screenings to acute services including inpatient hospital care and outpatient services, and chronic and rehabilitative care. In all cases, the services provided must be medically effective as defined through research findings; appropriate as determined by the patient, family and health care team; and timely -- without delay due to financial or administrative barriers. We also realize that there are societal interests that may be affected in the provision of care.

STRUCTURE

ALA/ATS POSITION: We favor a health care system that is a pluralistic public/private payment and delivery system. Mechanisms must be established to facilitate the requirement of employers to finance the health care benefits of their employees and employees' dependents. Supplemental benefits can be provided in whole or in part by the employer, or purchased privately by the individual.

We recommend that all federally-sponsored health care programs be consolidated into a single public plan.

We believe the new health care system should build upon our current public/private system. We support an employer mandated system in which mechanisms and incentives would be established to help employers finance health care benefits for their employees and the employees' dependents. Under this proposal, the employer could, for example, provide health care benefits directly as a self-insured program or purchase a group plan as long as the benefits financed by the employer include **at a minimum** all the services listed in the Benefits section on page 3. Employers would certainly be free to offer benefits above and beyond those mandated. Individuals also would be allowed to purchase supplemental coverage on their own, if they so choose.

It may also be necessary to effect changes at the federal government level with respect to small market insurance laws (i.e., guaranteed issue, guaranteed renewability, community ratings) to facilitate employer compliance. In addition, procedures must be in place to ensure that health care services are provided in instances of jurisdictional coverage dispute (e.g., workers' compensation versus traditional insurance).

We strongly believe that all federally-sponsored health care programs should be consolidated into a single public plan that provides all the services listed in the Benefits section on page 3. This plan would include

the Medicare program, Medicaid, Veterans' Administration health programs, CHAMPUS, community and migrant health programs, and so on. It would eliminate the duplications of administration and delivery of services among these many programs. It also would allow for a uniform public program that would not vary by state (as is the problem with Medicaid), and allow access to services regardless of the nature of the illness (as with the VA programs).

SYSTEMIC AND PROVIDER CONCERNS

ALA/ATS POSITION: <u>Administrative</u> -- The administration of the health care system must facilitate patient access to care. The administrative process of the health care system must be standardized for all payers, thus maximizing resources for actual health care services.

ALA/ATS POSITION: <u>Provider Reimbursement and Availability</u> -- Providers must be fairly compensated to ensure access to health care. This compensation should reflect provider cost, work, and time. Incentives must be developed to encourage an appropriate distribution between primary care and specialty physicians and a more equitable distribution of health care providers to ensure access to care in rural, inner city, or otherwise underserved areas.

We believe the system must be "user friendly" and easily accessible to patients. We believe the administrative processes of the health care system must be simplified and standardized for all payers so that more of our health care dollars are spent in providing health care services, and less for paying salaries of people hired to fill out forms. Reforms in this area could include electronic filing of claims, a single uniform insurance form, or "smart cards" for individuals.

We also believe all providers of health care (physicians, nurses, nurse practitioners, clinical nurse specialists, physician assistants, allied health professionals, and hospitals) should be reimbursed at a fair rate so as to ensure full access for patients to all providers. We also believe incentives must be created within the medical education system to ensure the availability of a full range of providers in all geographic regions, especially in areas that are traditionally underserved. A strong primary care network must be developed to act as the entrance point for individuals into the health care system.

To achieve these goals, we make the following recommendations: Improve academic preparation in middle and high schools; provide financial incentives such as scholarships, loan forgiveness or tax credits; revise clinical curricula in medical school to emphasize ambulatory care; equalize compensation between primary care and medical specialties; and reform the malpractice insurance system.

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INDIVIDUAL AND PUBLIC RESPONSIBILITIES

*ALA/ATS POSITION: **Education for health is the responsibility of many sectors of society including employers, schools, families, religious institutions, health providers and voluntary health agencies such as the American Lung Association, the American Thoracic Society, and others. Individual responsibility for health is crucial to an effective health care system. Through proper education individuals will become empowered, active, and aware of their responsibility for positive health behavior and maintenance of healthy life styles.***

We believe strong, comprehensive health education programs are an integral part of preventive health care. These programs will encourage individuals to maintain healthy life styles and take responsibility for positive health behavior.

Agencies such as the American Lung Association and the American Thoracic Society are ideally suited to provide leadership in this area. Public education is a primary tool used by the ALA/ATS to fight lung disease and promote lung health. We urge schools, families, health care providers, religious institutions, community organizations and others to join the voluntary health community in providing comprehensive health education.

FINANCING AND COST CONTAINMENT

*ALA/ATS POSITION: **Financing** -- The financing of universal health care should avoid placing an inappropriate burden on any individual or particular sector within society and will require a degree of government support. Any premiums, deductibles, and co-payments for the basic level of services should be uniform. An individual's ability to pay shall not be a barrier to care.*

*ALA/ATS POSITION: **Cost Containment** -- An employment-based health care system of universal coverage can be economically feasible only if there are cost containment features that address both aggregate budget expenditures and provider payments and are applied to all payers.*

We believe the health care system should be financed through multiple sources, including the government, with no one sector or individual bearing an unfair or disproportionate share of the costs. We support a progressively financed system and believe that any premiums, deductibles, or co-payments required must be based on an individual's ability to pay.

Finally, we believe cost containment is essential for maintaining a "healthy" health care system and that a variety of tools can be used to rein in the spiraling costs of health care. We suggest tools such as outcomes research, the development of clinical practice guidelines, reform of the medical liability system, electronic submission of claims, a single uniform insurance form, and such other tools as necessary to address aggregate budget expenditures and provider payments.

ALA\ATS Task Force on Health Care Policy

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Additional comments of Task Force members.

WASHINGTON UNIVERSITY SCHOOL OF MEDICINE
AT WASHINGTON UNIVERSITY MEDICAL CENTER

DEPARTMENT OF INTERNAL MEDICINE

Peter G. Tuteur, M.D.
Associate Professor of Medicine

October 20, 1992

Ms. Robyn Henderson
ALA
Washington Office
1726 M Street, NW, Suite 902
Washington, DC 20036

Dear Robyn:

The final draft ALA/ATS Task Force on Health Care is excellent. I think it reflects the consensus quite well.

Enclosed are a few notes that I think would help clarify and strengthen the document. First, under the topic "SYSTEM AND PROVIDER CONCERNS", I think the second paragraph should include an explicit statement concerning RBRVS and the use of conversion factor. One might consider language such as, "RBRVS should form the basis for the payment system using an appropriate conversion factor (CF) to determine absolute reimbursement levels."

I think this addition is necessary to reduce prevalent confusion among physicians and health policy makers regarding the interaction among RBRVS, CF, and the new coding system. Often, aberrations with the coding system and their sequelae inappropriately are blamed on RBRVS methodology.

In the section under "FINANCING AND COST CONTAINMENT", I think it is important to differentiate between a "universal health care" system and universal access to health care." In the subsection under cost containment it should be stressed that improved administrative efficiency is the primary cost containment approach and must be aggressively pursued before one limits health care services. I recognize that this is stressed elsewhere but it cannot be stressed enough. Comments above should also reappear in the section under SYSTEMIC AND PROVIDER CONCERNS.

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Robyn Henderson
October 20, 1992
Page 2

Finally, a statement is needed concerning the benefits associated with physicians' ability to "balance bill". Physicians should be permitted to maintain the right to determine their fees. Payors have the right to reject the fee and patients may seek health care elsewhere. Similarly, physicians have the obligation to maintain a constant fee schedule (identical CF). When insurance payors do not meet prospectively defined physician-determined CF, then it is the obligation of the patient (in part determined by means testing) to assume obligation for the marginal difference.

Robyn, i think the report is well done and reflects the sense of the Task Force. I appreciate the opportunity to participate.

Respectfully,

Peter G. Tuteur, M.D.
Associate Professor of Medicine
Pulmonary Disease Division

PGT:mah

STRATEGIC IMPLICATIONS
INTERNATIONAL
Marketing Consultants to the Healthcare Industry

January 12, 1994

The Honorable Pat Williams
Chairman
Subcommittee on Labor - Management Relations
Committee on Education and Labor
320 Cannon House Office Building
Washington, DC 20515

Ref: Comments for Record on Health Care Reform

Dear Mr. Chairman:

Thank you for the opportunity to comment for the record of your recent hearings on health care reform. Strategic Implications International is a healthcare marketing and communications firm, providing consulting services to the medical and pharmaceutical communities. We are extremely concerned about the potential effects of the proposed health care reforms on the price and availability of prescription drugs.

Health care reform, as being debated, is largely about the financing of medical services. It does not really address the well-being and actual health of the users of the system. Health care reform in its pure fiscal form will not make the average American live a year longer or enjoy a greater sense of physical comfort. That task will, as it has in the past, be left to pharmaceutical research and development organizations, which by virtue of their expertise and investment in this area, have done much to increase life expectancy in this country from age 54 in 1920 to age 75 today, while improving the quality of life every step along the way. As many as 90,000 tuberculosis deaths have been prevented. A million cases of polio also have been prevented, and 400,000 people have avoided lifelong paralysis and disability from that dreaded disease. Over half a million lives have been saved with the advent of coronary medications. Similarly, half a million people who otherwise would have died survived strokes to spend time with their families and loved ones.

If cost containment is an issue -- and apparently it is the major issue in some quarters -- ethical pharmaceutical preparations more than any other single factor are credited with shortening hospital stays and eliminating the need for expensive surgery. With drugs rather than surgery, people go back to work sooner, thus increasing

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American productivity and increasing tax revenues. Cardiovascular disease, cancer, Alzheimer's, AIDS, genetic abnormalities -- the list is endless of major health problems that are being attacked with increasing effectiveness by the pharmaceutical and biotechnology communities. The economic impact is great: a 40 percent reduction in cardiovascular cases attributable to more effective drug therapies saves $211 billion in indirect costs.

It takes an average of 12 years of research, testing, and review -- at an average cost of $231 billion -- to bring a new pharmaceutical compound from the laboratory to market. For every one that is pursued, over 5,000 fail to show sufficient promise and are abandoned.

Is there money in the system to support such a level of effort? As reported in The Washington Post on January 7, 1994, pharmaceutical research and development is a $70 billion pie and will grow by only 3.5 percent next year. The six most profitable drug companies suffered a median decline in return on equity of 47 percent. The top five drug companies now account for only 30 percent of the market. In contrast, the top five automobile manufacturers hold 80 percent of their market. The average prescription cost rose only 5.2 percent last year, a little more than half the increase of two years before.

Will the successful preparations end up fulfilling their function of alleviating pain and suffering and reducing morbidity and mortality as well as increasing the quality of life? Perhaps not. In today's managed care environment, cost is a paramount consideration. Reimbursement systems and the formulary policies of Health Maintenance Organizations and other managed care entities are already dampening research by discouraging or prohibiting the recommendation of certain pharmaceuticals.

Any proposed Advisory Council on Breakthrough Drugs has the potential of compounding this chilling effect on research. So-called "breakthrough drugs" account for only 1/500th of health care costs as it is. (Pharmaceuticals as a whole, for that matter, account for only 7 percent of total health care costs.) Most of the major pharmaceutical companies have compassionate use programs, under which certain patients may receive needed drugs at a subsidized cost or in some cases, no cost. To decide at a governmental level which drugs may be pursued or reimbursed at a reasonable level is to, in effect, nationalize the pharmaceutical companies. Does Congress mean to do this and does Congress believe

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volunteer advisory boards are the proper body to chart the future course of the one industry that is actually contributing to the well-being -- health, if you will -- of the American people?

We urge you to move with caution in this area. So much of the health care system is destined to change -- much of it at the same time. Would it not be better to know that the nation's pharmaceutical system stands strong and will continue to provide trustworthy and innovative medicines, no matter what financing system is ultimately put into place?

Thank you for your time and attention. And, again, we appreciate the chance to have our views included in the final record.

Sincerely,

Christos Efessiou

Christos Efessiou
Principal

CCBC
Council of Community Blood Centers

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Testimony of the Council of Community Blood Centers
by William M. Coenen
Administrator of the Community Blood Center of Greater Kansas City

for inclusion in the records of the
Education and Labor Subcommittee on Labor-Management Relations
hearings on healthcare reform

Mr. Chairman and distinguished members of the subcommittee, I am William Coenen, administrator of the Community Blood Center of Greater Kansas City, which serves the transfusion needs of the 1.9 million people in northwest Missouri and eastern Kansas. I am also president of the Council of Community Blood Centers, also known as CCBC, an association of independent community blood centers which are not part of the Red Cross network. CCBC is proud to represent nearly 80 percent of the blood and related services provided by non-Red Cross community blood centers. Our members collect all their blood for transfusion from unremunerated voluntary donors.

I am pleased to present CCBC's comments and concerns on President Clinton's Health Security Act. I first would like to set the foundation for my comments by describing the role our blood centers play in the healthcare system.

In many ways blood centers are the embodiment of the high-quality, efficient and cost effective healthcare providers envisioned by the President's plan. Blood centers are unique and indispensable not-for-profit community service organizations which are the stewards for nearly 90 percent of the blood provided by altruistic volunteers and people wanting to donate for their own use. Blood centers also provide over 40 percent of the nation's tissue services. We recruit the vast majority of volunteers who make bone marrow transplants outside of their immediate families. We are on the leading edge of many research therapies, such a stem cell collection and processing, that promises to improve the success rate of bone marrow transplants and cancer therapy. Many of our centers are providers of unique and highly complex diagnostic services within their communities. Finally, blood centers are

engaged in a broad range of educational activities and provide operational community benefits at little or no cost to the public which reinforce our not-for-profit status.

We believe that healthcare reform should preserve and build on our role in providing efficient and effective community services. Under a reformed healthcare system, blood centers could become an even more integral part of the value chain of regional healthcare. For example, we could actually expand the range of services we provide so that we are involved at every stage of blood distribution—from donors to recipients—saving millions of dollars in transfusion costs and improving safety by applying our state-of-the-art tracking systems to assure the right patient gets the right blood. Blood centers have also demonstrated time-after-time that we can provide a variety of therapeutic and diagnostic services with the same high quality as currently is available from other providers, and more cost-effectively than if multiple providers are duplicating services.

In the past, legislation involving certain aspects of health care has inadvertently overlooked blood centers. As a result, unintended consequences have adversely affected community blood centers, and, therefore, threatened vital services provided in the public's interest. I hope that any efforts to reform the healthcare system will take into consideration blood centers' unique role and allow us to provide even more efficient and dependable services to the individuals and communities relying upon our skill and products. We intend to carefully examine legislative proposals for healthcare reform and work with Congress and the administration to assure that blood centers can continue to be models of community health services.

I now would like to address specific ways in which the President's reform plan could have an enormous impact on blood centers.

Blood Services Coverage for All Individuals

CCBC supports the inclusion of blood services under the President's basic health benefits package. Consequently, outpatient, home and community-based services should be covered when performed by blood centers on direct orders from physicians or other health professionals.

Blood is unique in that it is considered as both a biological service and a drug. Because the administration's proposal expands Medicare outpatient benefits to cover prescription drugs, Congress should specifically consider including blood and blood transfusions as part of any new Medicare drug benefits. However, due to the not-for-profit nature of community blood centers, blood should continue to be excluded from

drug rebate requirements, consistent with current Medicare practice for inpatient care.

Protection of Medical Innovation and Research

CCBC supports funding for research into new medical technologies. Investigational treatments performed by community blood centers (e.g., stem cell collection and therapeutic hemapheresis) should be covered under a new healthcare reform system.

Further, CCBC supports inclusion of a new funding mechanism to support federally-funded medical innovation and research, such as transfusion medicine research to improve the safety of the blood supply.

Cost Containment/Price Flexibility

CCBC is vitally concerned that under a reformed healthcare system, should new tests be mandated or new FDA, CDC or alliance regulatory requirements be put in place, blood centers must have the flexibility to adjust prices (e.g., for blood components, tissues and new biologicals) to reflect any increased operating costs imposed by virtue of compliance with such new regulatory requirements.

Thus, while we support President Clinton's commitment to healthcare cost containment, we request clarification and protection. Any price and premium control provisions must allow for flexibility in the face of increased regulatory burdens.

Optimizing the Role of Blood Centers as Vital Health Providers

Many aspects of the President's plan and other proposals being considered by Congress would alleviate some of the regulatory and paperwork burdens faced by community blood centers and allow us to augment the services we provide to blood recipients and healthcare providers. Specifically, CCBC supports proposals to:

* Reform medical malpractice to require alternative dispute resolution, certificates of merit, and demonstration projects for enterprise liability and practice parameters. As providers of professional services, blood centers should specifically be included in any medical malpractice reform provisions.

* Preempt state laws limiting the scope of practice of healthcare professionals. Blood centers would like to see all such artificial barriers removed for blood center professionals and operations. We are confident these reforms will increase our efficiency without

compromising effectiveness.

* Ease regulations implemented under the 1988 Clinical Laboratories Improvement Amendments (CLIA) to alleviate the regulatory burden on laboratories. CCBC supports exempting more tests from CLIA regulations, grandfathering current lab technicians who do not meet CLIA personnel standards for certification and training, and streamlining laboratory inspections.

* Reform antitrust laws to remove barriers to collaborative arrangements between healthcare providers. CCBC supports protections for blood center joint ventures and purchasing arrangements.

* Institute standardized medical forms and reimbursement procedures. To increase efficiency, blood centers would like to be able to use standardized forms and claim procedures when performing applicable services.

While we strongly support the previously mentioned reforms, CCBC is concerned that some of the provisions in President Clinton's plan could pose new regulatory burdens and impede efficient delivery of community blood services.

First, we would like to see current federal exemptions for blood centers remain intact under expansions of Medicare and Medicaid anti-kickback and self-referral restrictions. CCBC also is concerned that restricting healthcare alliances from crossing state lines might have unintended, and adverse, consequences for community blood centers. At this preliminary stage, it is unclear how such restrictions could affect blood centers operating in several states. CCBC urges that any enacted legislation provide necessary flexibility that would encourage multi-state operations of providers.

In addition, blood centers commend the administration's commitment to quality management and consumer input. However, we believe it is critical that the Food and Drug Administration (FDA) maintain statutory and state-of-the-art safety authority over blood collection and processing regulation by preempting state and local regulations.

Finally, as Congress continues to consider specific legislative proposals for healthcare reform, CCBC may wish to submit additional comments and concerns. For example, to cite just one area, as the issues relating to non-profit organizations receive further consideration, we look forward to the opportunity to consult with congressional committees. We want to work with Congress to continue to explore how community blood

centers will fit in the framework of healthcare reform.

Until that time, Mr. Chairman, I thank you and the subcommittee for your consideration of the issues outlined above.

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STATEMENT OF THE
AMERICAN UROLOGICAL ASSOCIATION
ON HEALTH CARE REFORM
LEGISLATION

The American Urological Association (AUA) is pleased to submit the following statement on behalf of the 6500 board certified urologists who provide medical and surgical services to men and women, specializing in conditions affecting the urinary tract and male reproductive system.

AUA is concerned over the rigidity of the budget and structure in the President's health care reform proposal. We are opposed to a fixed national budget for health. We are not opposed to reasonable, responsible efforts to expend resources as economically as possible. Fixed budgets or caps will not promote, nor will they allow, the kind of cost effective system we need to develop.

The structure of alliances proposed by the President appears to be overly bureaucratic and unreasonably limits the role of physicians in the governance of these systems. More flexible and efficient management forms need to be found. Health care has more than enough bureaucracy today. We do not need to add to it under the guise of "reform".

MEDICARE

Urologists generally see a large number of Medicare patients because many urologic diseases are age related. Prostate cancer and urinary incontinence are two of the many conditions associated with the aging process that our members treat. HHS data show that 71.8 percent of urologists accept Medicare assignment, compared to the national average for all practitioners of 59.8 percent. Ninety-seven percent of urologists continue to accept new Medicare patients, according to a poll conducted for AUA by the Gallup Organization.

We are deeply concerned that the President wants to cut the Medicare program dramatically to finance health care reform. Medicare could not absorb a $124 billion reduction in spending on top of the other reductions already enacted without negative consequences to patient care. If there are costs to implementing health care reform, then they should be shared among us all.

We appreciate the reinstatement of fee equality for "new" physicians, and will continue to work with the Committee to clarify other Medicare issues such as actual overhead costs. We are committed to improve the CPT coding system and resource based relative value scale to assure both appropriate coding for medical services and reasonable reimbursement. We hope that you will consider our voluntary efforts as proof that medical societies are willing to participate constructively in decision-making affecting our patients and practices.

Some members of Congress have advocated expanding Medicare as the way to solve the nation's health care access problems. While this approach would continue many elements which we strongly support, such as fee-for-service and freedom of choice for patients and physicians, we would be reluctant to see Medicare extended to other sectors unless substantial improvements are made to the program. Among our concerns are the following:

- Health spending would be an even larger item in the federal budget, and even more subject to continuing deficit reduction pressures and competition for scarce federal dollars. Health care funds should be better insulated from the political process in order to assure service continuity and quality for patients.

- Over the last six years, urologists have felt the impact of yearly Medicare reductions targeted at surgical services, and the across-the-board cuts resulting from the implementation of the Medicare Fee Schedule. Program rules change constantly as a result and have become too complex and cumbersome.

- Our concern in using Medicare as the basis for a single-payor system also relates to the many inconsistencies in program operations, frustrations with the transition to the Resource Based Relative Value Scale and too much paperwork. For example, urologists who place a catheter in a patient during an office visit must file the claim for the catheter with a regional durable medical equipment carrier, rather than the physician's carrier, requiring extra time and paperwork.

- Urologists who perform laboratory tests in their office have been suffering the paperwork and costs of the Clinical Laboratory Improvement Act of 1988 (CLIA'88) overregulation.

We have worked with Health Care Financing Administration (HCFA) and the Centers for Disease Control and Prevention (CDC) to reduce some of the burden, and hope that the Committee will support substantive improvements to CLIA and in the paperwork and reporting hassles endured by physicians.

- Medicare's benefits and coverage are not always current. The program is often slow or inconsistent in evaluating new services and incorporating them into the program. A vastly improved coverage process would be needed. For example, AUA is working with HCFA on four specific, technical payment/coverage issues. Progress is slow, in large part because there is no clear system in place to resolve these types of issues.

PHYSICIAN SUPPLY

AUA strongly believes in freedom of choice of provider for the patient. Patients should continue to have the opportunity to see a urologist as an initial point of contact without first going through a "gatekeeper". This saves time and money by allowing the patient to be evaluated, and treatment initiated, in the same visit, early in the onset of the condition when treatment choices may be most effective. We are concerned that the current emphasis on primary care might establish unnecessary barriers to urologic services and diminish access to specialized care.

We are also concerned about the proposed ratios for training specialists and generalists. Ten years ago urology teaching programs voluntarily trimmed numbers and improved residency quality. Currently, there are 8330 practicing urologists in the country, a ratio of 1:30,335, based on the general population of 252,688,000. Demand for the services of most urologists remains high. Our members are busy and working hard. When considering the rate of growth in the over-65 population, who experience a greater incidence of urologic conditions, it is conceivable that the current ratio will be insufficient to meet patients' needs. For example, a urologist employed by Kaiser Permanente in southern California estimates their ratio of urologists to patients is 1:40,000, but theirs is generally a working-aged population, not retirees. Their ratio would have to change if greater numbers of retirees were participants. We urge the Committee to resist efforts to impose arbitrary limits on the number of urologists in training.

AUA supports the role of teaching hospitals in medical education, research and specialized care, and recommends maintaining federal and private financial commitments to these institutions.

4

SCREENING AND PREVENTIVE CARE

Prostate cancer is one of the leading causes of death among men. Early detection through digital rectal examinations and prostate specific antigen (PSA) testing allows physician and patient more treatment options to contain the cancer before it spreads to other organs, becoming impossibly painful in its last stages. Although the President has emphasized the importance of prevention and screening, the outline of his plan does not include early detection for prostate cancer. This omission should be corrected.

The AUA recommends that annual PSA testing and digital rectal examinations should be performed on asymptomatic men over age 50, and over age 40 with a family history, to provide early detection for prostate cancer. The American Cancer Society supports this recommendation.

GUIDELINES AND OUTCOMES RESEARCH

There are many unknowns in the treatment of prostate cancer, and AUA is actively involved in promoting basic research and developing practice guidelines to clarify our current knowledge. We sponsored a symposium in 1993 on many of the issues surrounding treatment of this common cancer. This meeting helped clarify areas of agreement and identified other issues needing further study. We are currently supporting guideline development panels in six areas of urologic care, including prostate cancer, utilizing Dr. David Eddy's methodology. The prostate cancer guidelines will be based on the best available peer-reviewed scientific literature, and include active participation by non-urologists, including an oncologic radiologist and an internist who is associated with Dr. John Wennberg's outcomes research project on prostate disease.

AUA initiated the guideline on treatment of benign prostatic hyperplasia, which was taken over by the Agency for Health Care Policy and Research. It was released in February. Our initial achievement in this project was the publication of a BPH symptom index, among the first validated scales to evaluate the patient's condition before and after treatment. This index has been endorsed by the World Health Organization, and is considered by HCFA's Office of Medical Review to be a benchmark for their future quality assessment activities. The index helps urologists and BPH patients make better diagnostic and therapeutic choices and has the potential to reduce significantly the costs of diagnosing and treating this common condition.

We are nearing completion of guidelines for the treatment of kidney stones. This three year project involved a tremendous

commitment of volunteer time. Guidelines on the treatment of bladder cancer, impotence, pediatric conditions, and female urinary incontinence are expected to be completed within the next year or so.

AUA urges the Committee to emphasize the continuing development and refinement of practice guidelines with the direct input of physician specialty societies as a key part of national health reform. Federal support for basic research, outcomes research and guidelines development needs to be increased.

We believe that practice guidelines can promote quality, cost-effective care and ultimately save money by reducing unnecessary testing and procedures. They can help us all spend money for health care more wisely.

NEW TECHNOLOGY ASSESSMENT

AUA supports the development and dissemination of new techniques and technology where its efficacy has been demonstrated and reported in peer-reviewed literature. All too often, new technology moves into practice before it is sufficiently evaluated. Considerable expense could be avoided by reaching agreement on the evaluation of new technology. We have worked closely with the FDA to develop protocols for evaluating new technology, such as lasers used in treating BPH. As an organization, we have taken positions on new procedures and services that have made some of our members unhappy, but we are committed to assuring quality patient care, and scientifically validated treatment.

TORT REFORM

Cost-effective care can be promoted through tort reforms, similar to those adopted by California. The President's proposal does not go far enough toward correcting the weaknesses of our medical liability system. True tort reform will save society money and reduce unnecessary defensive medicine. Our Gallup poll results show that fifty percent of urologists perform additional tests because of litigation fears.

ANTI-TRUST REFORM

AUA recommends modification of the anti-trust laws and their interpretation to allow physician negotiation and the formation of physician and physician/hospital networks. This will promote efficiency through the sharing of equipment and facilities. It will also promote the participation of physicians in decision-

making and negotiating quality care arrangements and equitable compensation.

Attached is a summary of our policy positions on national health care reform. We would be happy to answer questions on these and other issues, and to continue our dialogue in the weeks and months to come.

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Policy Principles on Health Care Reform

The American Urological Association is concerned about the many Americans who have no health insurance, limited coverage, or fear losing their current plans. AUA supports legislation that would provide access and appropriate coverage. National legislation should include the following principles to assure the continuation of quality urologic patient care:

1. Freedom of choice. Patients should continue to have the opportunity to see a urologist as an initial point of contact without first going through a "gatekeeper;" and should have the opportunity to go outside of the plan at the patient's own expense.

2. Principles for Accountable Health Plans. The AUA recommends that at a minimum, AHPs meet the following requirements:

a) AHPs are not the exclusive mechanism for providing services.

b) Any plan may be eligible to compete for designation as an AHP, whether capitated or fee-for-service.

c) Physicians are permitted to join as many of the competing AHPs as they choose. Physicians are permitted to form AHPs and serve in key governance/management positions. Physicians are provided a structure for participating collectively in all levels of decision-making and issues concerning the AHP.

d) The criteria for selecting participating physicians are public, and termination procedures reflect appropriate due process and appeal.

e) Financial incentives related to the referral of individual patients are prohibited.

f) If the plan conducts economic profiling of physicians, adjustments are made to reflect individual physician's case mix, age and patient severity of illness, and other features of the physician's practice.

3. PSA testing should be included as part of the basic benefit package. Annual PSA testing and digital rectal examinations should be performed on asymptomatic men over age 50, African-American men over age 40, or men with a family history of prostate cancer, to provide early detection for prostate cancer.

4. Limits on new technology until validated by prospective randomized trials with at least one year's data. AUA supports the development and dissemination of new techniques and technology where its efficacy has been demonstrated and reported by prospective randomized trials with at least one year's data. The published data should be based on a prospective, randomized study comparing the standard and the new device.

5. Practice guidelines should be incorporated in health care reform. Should health alliances and AHPs undertake the assessment of quality of care and/or utilization controls, the AUA recommends the use of practice guidelines developed by or with the direct input of physician specialty societies.

6. Prioritization of health expenditures. Should the level of benefits and/or access of uninsured be limited by budgetary concerns, the AUA recommends a process similar to the Oregon Medicaid plan, whereby an independent body, including physicians and consumers, conducts a study of societal interests, and formulates a priority list of covered health care services.

7. Urologic care should be provided by urologists. Should health alliances and/or AHPs establish selection criteria, then AUA recommends that urological care be provided by urologists who have completed Residency Review Committee-approved residencies and have demonstrated continued competence in the field of urology.

8. Urologists Provide Ultrasonography. AUA affirms that urologists are the physicians best trained to diagnose, manage, and treat diseases of the genitourinary tract in patients of all ages. This includes possessing the skills in all aspects of diagnostic technology including ultrasonography and other imaging techniques. There should be no economic disincentives for urologists to perform these services.

9. Funding for outcomes research and guidelines. In order to meet the demands for treatment guidelines and outcomes assessments, there should be increased federal funding to support efforts conducted by and including physician specialty societies.

10. Support for teaching hospitals. AUA supports the role of teaching hospitals in medical education, research, and specialized care and recommends maintaining federal financial commitments to these institutions.

11. Antitrust protection. AUA recommends the enactment of appropriate antitrust relief to allow physician negotiation and the formation of physician and physician/hospital networks.

12. Tort reform. AUA recognizes the burdens of the current malpractice liability environment and supports tort reform similar to the plan in place in California.

Approved by the Board of Directors, January 1994

THE ROLE OF PATIENT SATISFACTION IN THE NEW HEALTH CARE SYSTEM: CONCEPTUAL ISSUES AND METHODOLOGICAL RECOMMENDATIONS

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I. THE IMPORTANCE OF PATIENT SATISFACTION TO ASSESSING THE QUALITY OF CARE

Whatever form a new health system takes, it will undoubtedly include a significant element of **accountability**. The public will be given information about the quality of care. Hospitals are already providing data to the public. HCFA has been publishing hospital mortality figures for several years, and the JCAHO began releasing selected accreditation evaluations in January of 1994.

Outcome measures and other quality indicators will gain increasing importance as providers compete for inclusion within the new plans, coalitions, and alliances. Any new health care system will have to include monitoring and disclosure of information on the quality of care as key elements in the selection and quality control of providers. The identification of useful outcome indicators is currently under discussion and development. Hospitals already provide mortality figures and certain other data to HCFA, as well as to malpractice insurers, and state health entities. Many also contribute data (infection rates, DRG-adjusted length of stay, etc.) to parent organizations or systems, or to local business coalitions with whom they contract for PPO status. Most hospitals also monitor patient satisfaction on a continuing basis. To date, little quality and outcome information is requested of physicians. It is assumed that this will change under a new health care system.

Of all outcome and quality measures, **patient satisfaction** is perhaps the most broadly useful. Patient questionnaires explore the quality of multiple hospital processes.

Patient satisfaction is a reflection of patient experiences with, and perceptions of health care. As such, it captures the evaluation of the ultimate recipient of care. It is non-invasive and minimally threatening. A good satisfaction survey evaluates a wide range of experiences with the provider. For the hospital, patient surveys can produce evaluations of various departments, specialties and specific nursing units, as well as of care delivery processes that cross over different hospital sectors.

Are patients capable of evaluating the real quality of hospital care? Studies indicate that they are. Logically, too, when patients are satisfied with their care, they are more trusting, more compliant, experience less stress **and** the "placebo effect" is enhanced. This translates into higher quality care and better outcome. This means better value.

Consider just one example. On Press, Ganey's hospital patient survey, we ask "How well your blood was taken (quick, little pain, etc.)", as well as "Courtesy of the person who took your blood". The scores of these two items are highly correlated.

This means that when one goes up or down, the other does the same. It makes sense. If the patient is put at ease by the phlebotomist, stress is reduced, and peripheral vessels are more relaxed. The result is an easier "stick". It is impossible to distinguish between the **technical** and the **interactive** elements of care in this instance. They are parts of a single process, and the patient evaluates them as such.

Patient satisfaction, therefore, is a legitimate indicator of the quality of care. Moreover, it is an easily understandable indicator. Mortality figures, infection rates, procedure numbers, newborn "APGAR" scores and other technical indicators of quality are difficult for the average person to comprehend, let alone evaluate. "Spin doctors" also attempt to explain away problematic technical indicators ("Our mortality figures are high because we're a dumping ground for regional hospitals"). You can't put a spin on patient satisfaction, however, and the figures are quite easy to comprehend. We believe it to be such a useful and accurate indicator as to warrant its mandatory inclusion as a primary element of any new health system.

II. IMPLEMENTING PATIENT SATISFACTION MONITORING IN THE NEW SYSTEM

Patient satisfaction data will be essential quality assessment tools at all levels of health care provision and organization. Each provider will need ongoing satisfaction data for continuing quality improvement programs. To encourage a continuing concern for quality, each and every provider entity -- individual physician practices, group practices, hospitals, free-standing clinics, home health agencies, etc. -- should be required to monitor patient satisfaction on a continuing basis.

At the same time, each health care plan and alliance or coalition will need information from the patient/consumer on satisfaction with the organization, accessibility, and quality of care being offered. This important information will help the plans and alliances to identify and select among high quality providers while also identifying and improving problems at both the plan and individual provider level.

It is easy to become enthusiastic about the importance of patient satisfaction monitoring to both provider and consumer. There is much talk today about the advantages of comparing data and "benchmarking" against the performance of peers. President Clinton's proposed health plan suggests that data on quality of provider care be collected at the national, as well as state and

local levels. While it is clearly useful and essential to collect comparative data on the quality of health plans and individual providers offered to a single consumer group, the utility of broader comparisons is less obvious. Patient satisfaction with plans and specific providers at one end of a state is not particularly relevant to users of different plans and providers hundreds of miles away. It is difficult to imagine what a state itself would do with satisfaction data from a number of alliances, coalitions and plans. Quality control must lie at the local consumer level, where direct contact with plans and providers in a competitive setting offers the most direct pressures for continuous quality improvement. As the purpose of the data is to provide consumers with a basis for selecting among specific plans and providers, plus provide plan managers and providers with help in identifying specific areas for improvement, there would seem to be little use for such data beyond or above the level of the local consumer/provider community.

In order to compare plans and providers, the satisfaction data within a local healthcare area must be collected and analyzed by a single entity. A single standardized survey instrument must be used, as well as a single data analysis and reporting format. For credibility, analysis cannot be carried out by a plan or provider (i.e. hospital). This would be a conflict of interest. Thus, any organization that offers competing plans to the public (business coalition, large employer, alliance, etc.) must itself take responsibility for monitoring patient/consumer satisfaction with the plans and their constituent providers. Of course, the actual data collection and analysis could be contracted out to an external vender.

We recommend against satisfaction monitoring by a single centralized entity at the national level that would be responsible for implementing, and analyzing surveys of all health care plans and providers in the country. This would be immensely cumbersome and costly. Quick turn-around of results would be unlikely. The same can be said for state-wide data collection. Satisfaction monitoring must remain a local level responsibility.

Patient satisfaction with plans and providers should be measured annually. More frequent monitoring incurs more cost, and also endangers response rates. As hospitals and other providers will (and should) themselves be surveying patients on a continuing basis, frequent monitoring by other entities will inundate patients with surveys, resulting in a diminished return rate for all concerned. This diminishes the validity of the results.

III. SUMMARY OF RECOMMENDATIONS

1. Patient satisfaction is a valid, sensitive, and cost effective indicator of health care quality. It should occupy a central place in any new health system.

2. Continuous patient satisfaction measurement should be mandated for all health care providers. Data are to be used for internal continuous quality improvement programs. Providers may conduct their own surveys and analyses or contract with outside independent vendors. Accreditation of providers should be contingent upon evidence of continuous patient satisfaction monitoring and use of the data for quality improvement.

3. Patient satisfaction with plans and providers should be monitored by every entity offering plans to the public. Annual monitoring is sufficient. Results of the surveys should be made public, and used for both selection and monitoring of providers' quality over time. Data collection and analysis may be conducted by professional contractors.

4. The patient satisfaction measurement that is presently being done efficiently by the private sector should continue, rather than add another public agency.

H.R. 3600—"THE HEALTH SECURITY ACT: EFFECT OF REFORM ON UNDERSERVED URBAN AND LOW-INCOME POPULATIONS IN HOUSTON, TEXAS

MONDAY, FEBRUARY 21, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS,
COMMITTEE ON EDUCATION AND LABOR,
Houston, TX.

The subcommittee met, pursuant to notice, at Northeast Campus, Houston Community College, Houston, Texas, at 1:30 p.m., Hon. Gene Green, presiding.

Also present: Representatives Green and Becerra.

Staff present: Phyllis C. Borzi, counsel for Employee Benefits.

Mr. GREEN. Welcome to Houston Community College, Northeast Campus. In fact, those of you who live in this community, it's surprising to come to a place where I grew up at and there used to be a department store here. But now it's providing educational opportunity for our young people and some of us that are not so young.

Thank you for being here this afternoon. I'd like to welcome Congressman Xavier Becerra and thank him for traveling here from Los Angeles to participate in this hearing. Congressman Becerra represents an area surrounding downtown Los Angeles, which gives him a district similar to the 29th Congressional District.

Congressman Becerra was a member of the State Assembly in California before being elected to the newly created 30th District in California. We serve on the Education and Labor Committee together, as well as each of our three subcommittees, which show we share a lot of the same interests.

Since he was elected, Congressman Becerra has established himself as a leading expert on bilingual education and he largely is responsible for drafting the new bilingual education bill that was endorsed by the Congressional Hispanic Caucus.

We're here today for a meeting of the Subcommittee of Labor-Management Relations, which will be considering a large portion of the health care reform plan submitted by President Clinton, as well as a number of other plans drafted by other members of Congress.

You are all probably aware of the President's plan since it's been so well publicized. However, there are a number of other plans that merit consideration and we'll be taking a close look at all those plans, as well.

There are three critical elements that any plan that passes Congress should contain; universal coverage for all its citizens, prescription drugs should be covered under Medicare, and individuals should be able to choose their own physicians or their own doctors or health care providers.

Health care coverage is critical for working families, since, at any time, an injury or illness could cripple a family financially with high medical costs. Low income inner-city families have a particularly hard time obtaining coverage since employment often is the only means of obtaining this coverage, and inner-city jobs often do not offer the coverage and are hard to come by.

Working families can expect to see their share of health care costs triple over the next 10 years if nothing is done to control the rising cost of health care and our Federal budget deficit will continue to grow until health care costs are brought under control.

Working families cannot afford to be paying a larger percentage of their income for health insurance and their only option is to drop that coverage. When that happens and they get sick or have an accident, the cost is shifted to taxpayers or to those who have insurance. The only way to solve the problem is to have some type of universal coverage so everyone has coverage and no costs are shifted from one group to another.

The focus of today's hearing will be on how we can best serve both low-income and underserved people as part of our health care reform. We are fortunate to have with us Sally Richardson, who is the Director of the Medicaid program, who will speak on behalf of the Clinton Administration's health care proposal.

We also have with us Robert Schaper of the Texas Hospital Association; Dr. Jorge Guerrero, who is a practicing physician here in the 29th District in east end Houston; Jane Nerison, Manager of the Compensation and Benefits for Lyondell Petrochemical Company, an employer in our district; Mary Walker, the Houston Regional Director of the AARP; and, Joyce Gilliam, owner of Fiesta Loma Linda Restaurant in east end Houston.

Thank you for being here this afternoon. We're looking forward to hearing from you and working with you on creating a health care system that is more efficient and that we can be proud of.

Once the witnesses who are here are finished, we will have open testimony for someone who would like to testify and you're welcome to testify as long as we can keep a quorum here or stay here, because this hearing is designed not just to hear from the invited witnesses, but from people who have the opportunity to be here and maybe not have the opportunity to go to Washington to testify.

I'd like to at this time recognize Congressman Becerra and say welcome to Houston and to northside Houston, if you have any prepared remarks or opening statement.

Mr. BECERRA. Thank you, Congressman Green. Thank you very much. I would like to just pass along my greetings to all of you here. Houston has a little bit different weather than Los Angeles does at this time of year, but you don't have to worry about earthquakes the way we do. So I think you may have one up on us in that sense.

Mr. GREEN. They can't hear you.

Mr. BECERRA. I was passing along a greeting and I would like to first of all thank Congressman Gene Green, one, for taking the time and the initiative to make sure that all of you here in Houston have a chance to get a better understanding of what is going on in Washington, DC these days when it comes to health care reform.

When I had a hearing in Los Angeles, there were many people who would come up, take the mike and ask questions, and it was very clear that they were very concerned and confused about what was being done and said as far as health care reform. It's through these types of forums that we give people an opportunity to know what we are doing as representatives of the people we represent.

I have been very fortunate to be able to work with Gene Green as one of the new Members of Congress. Our first collaboration probably was the Family Leave Act that was passed more than a year ago. Since that, we've worked on the Elementary and Secondary Education Act on the Education and Labor Committee, and also on a School-to-Work initiative which we hope will provide those people who are finding that it's tough to find a replacement job or go into the market to begin with with the skills that they need to go out there and either adapt to a new environment or readapt to some of the skills that they thought they had lost.

I'm looking around this room and I'm seeing a lot of the same faces and same looks that I saw in Los Angeles when I held the hearing on health care. There is a great deal of interest, I understand, to really grasp what will happen in Washington, DC. I suspect some of you in this audience have insurance. A number probably are at risk of losing it and you're probably wondering what we will do to make sure, one, you have good coverage; two, we don't make you pay more than you already pay; and, three, that it ends up being a system that ultimately in 10 years we'll still be proud of.

So I'm very much interested in hearing what the witnesses have to say today, but perhaps I'm more interested in hearing what you all have to say, because perhaps the most interesting thing that I found out of the hearing in Los Angeles that we held was that people had some very, very particular points that they wanted to stress.

I think that we often neglect or overlook because in the whole big picture, the small things that people bring to our attention often escape us in Washington, DC. So I'm very much looking forward to hearing what you have to say and I do hope that you will take the time to take the mike once the formal witnesses do finish their testimony.

So I thank you, Congressman Green, for letting me be here, constantly working collaboratively with me on a number of efforts, and I'm very proud to be able to say that we've been able to work very closely and very well together on a number of different issues. I'm just pleased that I was able to join you here today and hear from the witnesses that will come before us today.

Thank you.

Mr. GREEN. Thank you, Congressman. We'll start with our testimony. Our first witness is Sally K. Richardson, Director of the Medicaid Bureau, Department of Human Services. I would also like

to ask you, I know you have to catch a plane later, but if you could also be available after we hear some other witnesses to answer questions, because the biggest concern I hear from my constituents is, in particular, problems on how the President's plan will address some of the particular problems we're going to hear today.

So welcome, Ms. Richardson. We're glad to have you in Houston with us.

STATEMENT OF SALLY K. RICHARDSON, DIRECTOR, MEDICAID BUREAU, HCFA, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. RICHARDSON. It's a pleasure to be here. If they can't hear me, let me know.

Mr. GREEN. They're having a hard time in the back of the room. Is there any way we can turn up the mikes?

Ms. RICHARDSON. I really consider it a real privilege to have the opportunity to come to Houston to be with Congressman Green and Congressman Becerra and to be able to discuss with them the President's Health Security Act, particularly how it is geared to meet the health needs of underserved, vulnerable Americans who live in inner-city urban areas.

Both Congressman Green and Congressman Becerra have been very forthright in speaking out about the health crisis that is facing urban Americans living in inner-city areas and really these areas epitomize, I think, for us the problems and the consequences of this country's lack of health security. We might call it, as a matter of fact, our health insecurity.

Compared with other parts of the country, inner cities and isolated rural areas have a much greater proportion of uninsured people. They have fewer health care providers. They have inadequate outpatient and inpatient facilities and very few economic resources to help create effective networks of health care delivery.

Yet, the need for health services in these areas is much greater. Many of their residents suffer from a disproportionately high burden of preventable disease and injury and crime, poverty, overcrowding, unemployment and violence make these inner city areas an unattractive environment for health professionals.

Harris County, Texas, for instance, and Los Angeles County in California both have among the highest rates in the country of uninsured persons. These uninsured rates particularly are troublesome among Latino communities, where they average in excess of 45 percent. I don't have very comprehensive provider statistics, but I can tell you that, for instance, in Los Angeles County, the physician-patient ratio in Huntington Park, which is an area that is overwhelmingly Latino and Black, is 3,550 to 1, while in west Los Angeles, which is predominantly a middle-income neighborhood, it is 396 to 1.

Even in east Los Angeles, which, again, is not as affluent a neighborhood, when they count all of the resident physicians in the county hospital there, the ratio is still twice as great as it is in west Los Angeles.

The President's plan provides a means for the first time to make health security a reality for all Americans, but it is more than just a system to finance care for those of us who are sick and who al-

ready have insurance. That's an essential goal, but it's more important to recognize that the President's health security plan focuses the health care system for the first time on the Nation's vulnerable, underserved populations, and it does this in two major ways.

The first way is to change the personal health care system that we have all—that has served us and provide, as Congressman Green pointed out, universal coverage for every American, no matter what their economic status, no matter where they live. That universal coverage is to a comprehensive package of benefits that not only provides acute care for our illness and injury, but also clinical, preventive and primary care that is available without cost-sharing.

This system is going to have report cards that focus the attention of those who provide health care on healthy outcomes for the members of their health care plans and to assure quality. Finally, the system has financial incentives for the first time to keep populations healthy instead of just to treat their illnesses and injuries.

But the second way that the President's Health Security Act focuses on relieving the disparity between groups of Americans, some of who have good quality health care and others whose health care is not nearly as good, is to assure access to the Nation's underserved populations.

Because providers and services will not necessarily follow purchasing power to urban neighborhoods with overwhelming social problems and because universal coverage is going to increase demand for primary care practitioners that are already in short supply and because the private market is not accustomed to providing social and support services that are needed by underserved vulnerable people, the Health Security Act of 1993 uses six interrelated approaches to make sure that underserved people not only have access to the full range of services that are in the comprehensive benefit package, but also have an adequate choice of providers who know how to meet their needs and to health plans that they have been used to reaching out to for their health care services.

There are, as I said, six approaches to this and I'm just going to list them and then talk very briefly about a couple of them, because I know that my time is running out.

The six access initiatives are to protect and strengthen the current programs that we call safety-net programs. These are the programs that have been developed by Congress over the years, in the last 10 to 12 years, to provide and assure adequate health care services to people living in inner city areas.

To increase the supply of health care practitioners who serve in underserved areas; to expand capacity in inner city and rural underserved areas; to provide additional enabling services, like transportation and child care and translation and additional kinds of health care services, social support services; and, to expand mental illness and substance abuse programs; and, finally, to create programs that are directed at school-aged youth.

In terms of the current safety-net providers, these are the programs that we know as our community health centers, our migrant health centers, our federally-qualified health centers that work in inner-city areas and in rural-isolated areas to bring health care to

populations which do not attract the mainstream of the private sector providers.

These are programs for the homeless, programs that provide family planning, the Ryan White Act that provides HIV and AIDS assistance, and maternal and child health. These programs are all going to be under the President's Health Security Act; not only maintained, but they are all due to be strengthened and providers funded under these programs will receive automatic designation as essential community providers.

This designation is going to guarantee for these very, very important provider centers both payment for covered services from any health care plan that is serving under the Health Security Act and also not only will they be guaranteed payment for the covered services they provide, vulnerable populations, underserved populations who have been used to receiving their health care services from these essential community providers will have continuing access to the practitioners who have been working with them, who have experience in meeting their needs, regardless of what health care plan they may choose to enroll in.

In addition to strengthening and protecting those current safety-net providers, one of the biggest needs under the Health Security Act is to increase the supply of health care professionals who serve in inner-city areas. I know you all are well aware of the National Health Service Corps and the programs it has provided. It has been maintained by Congress through the last 10 to 12 years and for the first time, in 1992, it was increased in strength, given money by Congress to begin to reexpand its initiatives into underserved areas.

It currently has a field strength of 1,600 and it will be increasing to about 8,000 by the year 2000. That's a wonderful turnaround in that program that has been achieved in the last couple of years. Twenty percent of the scholarships that will be given will be going not just to physicians, but also to nurses, nurse practitioners, certified nurse midwives. There will be efforts to redirect residency training, to substantially increase the ratio of primary care physicians from about a third to 55 percent, and we are going to double the support for training primary care physicians, physicians assistants and advanced practice nurses.

There are several special programs in the Health Security Act for the recruitment and retention to increase the number of minority health professionals that are currently practicing and that will come into practice in the future.

In terms of expanding capacity, the hope is to increase the ability of community and migrant health center programs to reach an additional two million people by the year 2000. That's a minimum of 11 million people who will be being served by those providers in that time.

In addition to that, they will create 3,800 new practice sites so that the service provided by those providers will reach different kinds of people at different sites where they don't now have access to services. In addition, they will be providing capital to renovate existing sites, and that will include inner-city public hospitals.

Finally, just a word about the school health initiatives. There are two of them. One is school health related services; that is, grants

to States and community partnerships that will link the provision of health services to school-based and school-linked sites so that we can reach an additional 3.2 million children through that mechanism in clinics that are directly related to their school. The second major initiative is a comprehensive school health education curriculum that targets grades K through 12 that will be addressing locally relevant health programs, because this will be a program that will come through the States, work with the States to help develop relevant health education programs for their populations.

Then, finally, besides those six initiatives, there is money and grant money in the Health Security Act to strengthen public health services. As you know, the Institute of Medicine has estimated that to prevent early deaths, about 70 percent can be prevented through quality public health services, whereas only 10 percent of the difference can be made in personal health services.

Yet, over the years, public health has had to give way as more and more of our Federal dollars have been absorbed by the needs of vulnerable populations and the underserved for personal health services. So the Health Security Act proposes reinvesting in public health by redeveloping a core public health program that speaks about dealing with communicable diseases, that talks about developing better environmental and occupational health services, and that deals with preventable injury.

In addition to those core public health programs, there will be a national prevention initiatives program where the Federal Government will work with the States and local communities to develop community-based prevention interventions directed toward smoking by children and youth, violence prevention, behavioral modification that will prevent chronic diseases, such as diabetes and heart disease, and then, finally, a prevention research program through the National Institutes of Health and other research organizations within the Federal Government.

I will stop there and answer any questions that you might have.

Mr. GREEN. Thank you, Ms. Richardson. I think a lot of the concerns—and I think I've probably gotten reams of paper on the President's plan and the specifics of it. The question I get and I imagine we'll get this afternoon is, and some of these can be really short answers, I guess, one, I've been told that the President's plan has no effect on VA; that someone who is eligible for VA right now would continue to be able to go to VA, although VA will now be able to accept other veterans who have other resources who want to go to VA and pay for them.

Ms. RICHARDSON. That's right.

Mr. GREEN. What about on Medicare? Because I know the President's plan expands the prescription and also the long-term care. I have a constituent who provided me with the cost of his Medicare costs now, his monthly amount that he pays to Medicare with his supplemental or his Medigap coverage, as we call it, and that has increased.

Well, the Medicare has increased every year, along with the insurance that he gets to supplement Medicare. How would we be able to tell somebody that we're going to be able to control their costs because they've seen their costs continue to increase in the last few years like other people?

Ms. RICHARDSON. People who are eligible for Medicare and receive Medicare, as you know, will have additions to their benefit package in the terms, as you mentioned, the prescription drugs and there is a new long-term care benefit that will be available to them.

But in addition to that, they will have a choice, should they want the choice, of choosing one of the health plans in an alliance, if that is what they would like to do. It might give them the opportunity to have a better cost-sharing arrangement, it might give them the opportunity to have a subsidy of their cost-sharing benefits, than they have now under the Medicare program. But it's up to them. It's their choice.

Mr. GREEN. For example, now—and I've been approached at a lot of our town hall meetings by seniors who have options now under HMO and there are two that I know of, and not giving either of the trade names, but Secure Horizons and Santa 65, and I've gotten lots of questions about that.

They have an option now that's a fairly recent option and I know a lot of them are taking advantage of it, at least that I hear from my office. Would that continue?

Ms. RICHARDSON. That will continue.

Mr. GREEN. And would they be able to change back and forth? Because that's another concern I have. If they go with their Medicare like they have now with their supplement and they change to an HMO or they go with one of the health care purchase cooperatives, then they could go back to Medicare.

Ms. RICHARDSON. That's right.

Mr. GREEN. That's not a lifetime decision they have to make.

Ms. RICHARDSON. It's not a lifetime decision. My understanding is that they have—they can make changes back and forth a couple of times before they really—to really test out those systems to find what suits them best.

Mr. GREEN. I guess the concern, and not just of seniors and Medicare, but also everyone, is that—but particularly with seniors—is because they've seen their Medigap coverage increase very year like everyone else's, and I know that's all our goals, is to try and limit those increases, but can you tell us specifically about how the President's plan would limit those increases if they stayed with their current Medicare plus they buy their own private supplement insurance?

Ms. RICHARDSON. The President's plan estimates that a percentage increase that will be substantially below the current level of increase in health care costs and if the system itself doesn't correct into those estimates—its been a while since I've looked at them. I think they're in the neighborhood of 7.8 or 7.9 percent.

If it doesn't stay within that, then there will be a cap on premiums for those alliances that cannot keep their health care costs within the determined national average.

Mr. GREEN. They can't hear back there.

Ms. RICHARDSON. I'm sorry. I told the Congressman that the President's plan proposes a national rate of increase which all alliances will have to—let me explain just a little bit, if I might, Congressman, about it. Everybody in the country, with the exception of Medicare, will be assigned to an alliance by where they live and the purpose of the alliance basically is to negotiate for all the resi-

dents who live in that area for cost-effective, affordable, accountable health care plans; that is, benefit plans from which an individual may choose themselves which one suits their needs and their families' needs the best.

It is the alliance's responsibility to maintain the health care costs for its area within that national increase. If it does not, if it is not capable of doing that, then there will be a cap on the premiums themselves that it pays those benefit plans on behalf of its members, and, therefore, the costs in that alliance will be maintained.

So far as Medicare goes, Medicare's projected increases are going to be kept at the national level.

Mr. GREEN. And that's both for Medicare plus the supplement amount.

Ms. RICHARDSON. Plus the supplement.

Mr. GREEN. The alliances that you talk about everyone will be assigned based on geography, for example, in north Houston where we live now, we have one hospital that's close. People wouldn't automatically have to be at that hospital, though. They'd have that choice between what alliance they go to.

Ms. RICHARDSON. That's right.

Mr. GREEN. They're not really assigned an alliance. It's their choice.

Ms. RICHARDSON. The alliance is basically like a large rural electric cooperative. That's the way I like to see it. I'm from a rural area. I came from West Virginia. So it's responsible for providing the health care for everybody in the area in which they live.

But what it offers are a variety of benefit plans with a variety of different health care practitioners and a benefit plan, and then you choose. In addition to the fact that you can choose your own plan and you can choose whether you want a fee-for-service plan, which is what a lot of Medicare recipients have now, fee-for-service medicine, or you can choose a health maintenance organization, or you can choose a middle plan where you have a panel of preferred providers, but if you want to go to another provider who lives outside that plan, you may do so for a relatively reasonable extra charge.

So there are a lot of options that will be available to people.

Mr. GREEN. There's a lot of questions that I know a lot of people here and I have, but I'm going to defer to Congressman Becerra, because I know he has some other questions.

Mr. BECERRA. Thank you. Let me see if I can get a little bit more into what an alliance is, because I know oftentimes people get very confused by it. Let's see if we can try to be real succinct in how I phrase the question and hopefully get the answer back, as well.

What obligations does a person have in becoming part of an alliance? Is it mandatory to be part of an alliance?

Ms. RICHARDSON. Yes.

Mr. BECERRA. So everyone who is going to be under—if we end up passing the Clinton health care plan, everyone in the Nation will fit under an alliance.

Ms. RICHARDSON. Everyone, yes. They will fit under an alliance by where they live.

Mr. BECERRA. So everyone will fit under an alliance. Now, the alliance will then—will it act, in a sense, as a negotiator-facilitator

for everyone who is part of that alliance in determining the number of plans, the availability of plans, the options within plans?

Ms. RICHARDSON. What it will do is it will negotiate for the best affordable price. It will maintain the standards of quality that are set by both the Federal Government and the State for plans in the State in which the alliance resides. It will make sure it will collect the money from employers and individuals and the government, both State and Federal, to pay and it will pay the plans on behalf of the individuals.

It will also provide quality consumer information to be able to compare plans so that an individual will know not only what the plan wants to tell them, but what really comparable relevant information is about how each of these plans compares with the other, not only in terms of the services that they provide, they all provide the same level of benefits, but the kinds of service, the hours, that sort of thing.

But also the quality of the services, the outcomes for those plans over time will also be reported to individuals so that they know what they're choosing as they make that choice.

Mr. BECERRA. Would it be fair, then, to somewhat characterize the alliance as a reception center for all the moneys that will be contributed by the employer and the employee or whatever source of moneys will be provided to pay for the health care? It will serve as the reception center for all of those funds and then will serve as a clearinghouse for the people who will be receiving the health care plan, their health care coverage, and it will also act as the negotiator to determine what types of plans will be available for the folks within that alliance.

Ms. RICHARDSON. That's right.

Mr. BECERRA. What happens when someone decides to move from Texas to California and is now leaving the jurisdiction of that alliance in, say, Texas?

Ms. RICHARDSON. There is established a kind of an interstate commerce or compact kind of arrangement between alliances. So someone not only can move from Texas to California to West Virginia or on and stay in their plan and have their services paid for, but they can—if they do travel out and need health care services in another place, they will also have those paid for by their home alliance.

They would be expected—I think there's a period of time that is written into the law within which—I think it's three months within which they would have, if they moved to a new area, to then join a new alliance.

Mr. BECERRA. And this is the important point about affordability of coverage, meaning if you go from one place to another, if you change jobs, you will not lose your coverage.

Ms. RICHARDSON. That's right.

Mr. BECERRA. That's where this becomes very important.

Ms. RICHARDSON. It's your insurance plan. You joined it. You take it with you wherever you go.

Mr. BECERRA. When you say it's your insurance plan and you take it with you, when you move from one alliance to another, every particular component of the insurance plan you currently have in, say, Texas may not be with you when you go to California,

but you will ultimately end up with a basic core group of benefits in any insurance you get.

Ms. RICHARDSON. Yes, that's right. And you do have the three months to make that change when you're living in California and you make a choice for a new plan that, again, fits your needs.

Mr. BECERRA. Let me ask you now in terms of Medicare. If you could, give us, and, again, briefly, without going into too much detail and becoming too academic, the guts of how the current system of Medicare differs from the Clinton plan version of Medicare.

Ms. RICHARDSON. I think the primary way that it differs is that it has a prescription drug benefit. That is the same prescription drug benefit that is contained in the alliance plan. It has an out-of-pocket maximum. It has a $250 deductible and then a 20 percent copay to an out-of-pocket maximum.

Mr. BECERRA. So let's make sure that's clear now. Currently with Medicare——

Ms. RICHARDSON. There is no deductible.

Mr. BECERRA. No coverage for prescriptions.

Ms. RICHARDSON. Not unless you're eligible for Medicaid.

Mr. BECERRA. Unless you're eligible for Medicaid. So you have to be not only elderly, but indigent.

Ms. RICHARDSON. That's right.

Mr. BECERRA. But under the Clinton plan, anyone who is eligible for Medicare under the Clinton plan would receive prescription drug coverage to a certain extent. You would have to pay $250 in a deductible.

Ms. RICHARDSON. You would have to pay $20—you also have to pay a premium that's under Part B and it is mandatory. So you would pay an additional $10 a month in your Part B premium. You will have the deductible. You will have a copayment as you purchase your drugs to an out-of-pocket maximum. Then, after that, the Medicare will pay the rest of the cost.

Mr. BECERRA. So if we have to tell people where's the break-even point on this, when will you—at what point do you no longer benefit under the Clinton plan for Medicare with the prescription coverage or at what point do you benefit, whichever way you want to look at it; is the glass half empty or half full.

What is the break-even point? Since you have the deductible and the copayment and the monthly payment, there is some costs and if you don't have a lot of prescription drugs to purchase all the time, you may end up paying more. But at some point, if you have a lot of expense when it comes to prescriptions, obviously, by having a cap on how much you will have to pay out of pocket, it does help.

So where about would be the break-even point?

Ms. RICHARDSON. If you look at the fact that—if your drugs cost you $60 a month, it would take you three months to have met your—four months to have met your deductible and you would be just close to breaking even. So at five months, if you drugs cost you $60 a month, you would be well into having—you're making money on the new drug benefit.

Mr. BECERRA. Under the Clinton plan, if you have $60 a month worth of prescription drugs, after five months, you would already

be better off under the Clinton plan than you would be under the current system.

Ms. RICHARDSON. That's right.

Mr. BECERRA. One last question, because I know we do have to move on. I have a concern with regard to the provisions regarding essential community providers.

Ms. RICHARDSON. Yes.

Mr. BECERRA. I have in my district in Los Angeles the Los Angeles General Hospital, a county facility, which——

Chairman GREEN. They can't hear.

Mr. BECERRA. Let me repeat that. In Los Angeles, part of the district I represent has the LA County Medical Facility, which is a fantastic facility. It helps a lot of folks who are seniors, a lot of folks who are indigent, and it's done a tremendous job.

The problem is it's a facility that's at least 70 years old. Now, its infrastructure, its machinery, most of its equipment is a little older than most of the newer hospitals. When we go into the new setting with the alliances and this competition for the alliances' business, I'm concerned that a lot of these hospitals that have done tremendous work in the communities that are underserved will now be asked to compete with hospitals that have been charging higher rates and getting private patients and they may not be able to.

What will be done under the new system to make sure that the hospitals that have been serving the community very well, but because they're public hospitals, they have a more difficult time getting the monies necessary to upgrade, will have a chance to compete and continue to serve in those areas that are somewhat underserved rather than close their doors?

Ms. RICHARDSON. There are two ways. One is, in the first place, beginning with the passage of the bill, there are going to be grant moneys for facilities like that hospital that you described, so that those hospitals can begin to become more competitive. They can get new systems. They can begin to upgrade their equipment. That's what that money is for.

But in addition to that, there are going to be grants and loans into inner city and rural area communities for networking; that is, for bringing public and private providers together in a community network to serve the population. Anyone who applies for and receives one of those grants to network in a community to link providers to serve communities will become an essential access provider.

So, basically, those county hospitals and small rural hospitals, which are also often county hospitals, that want to provide service on a network basis, linking with the community health center to get themselves into the position to be able to provide comprehensive services, will become essential community providers.

Mr. BECERRA. Thank you, Ms. Richardson.

Mr. GREEN. Thank you, Ms. Richardson. I see we have our second panel here and I'll allow as much time for citizen statements. Thank you for being here today and, again, I'd appreciate you staying as long as you can so we can——

Ms. RICHARDSON. I will. I'll go right over there and sit.

Mr. GREEN. Thank you. I'd like to call our next panel, Dr. Jorge Guerrero, Robert Schaper and Pauline Rosenau. While they're coming up, the statements of all the witnesses will be included in the record and hopefully the witnesses will summarize their testimony to three to five minutes at the most. That way anyone who wants to submit a written statement that's much longer, feel free to do so. You'll just need to get it to our office within two weeks from today and it will be included in the record on this.

Particularly, when you have the open testimony, you don't have to have written statements, but if you'd like to, feel free to submit them to our office and we'll include them in the testimony. We'll keep the five-minute time limit.

Welcome to our panelists. We'll start with Dr. Guerrero. Welcome, Dr. Guerrero.

STATEMENTS OF DR. JORGE GUERRERO, M.D., PARKVIEW CLINIC, HOUSTON, TEXAS; ROBERT F. SCHAPER, PRESIDENT AND CEO, TOMBALL REGIONAL HOSPITAL, HOUSTON, TEXAS; AND PAULINE ROSENAU, ASSOCIATE PROFESSOR, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER, HOUSTON, TEXAS

Dr. GUERRERO. Good morning. Thank you very much. My name is Jorge Guerrero. I'm a family practitioner here in Houston. I will just briefly give you a background. I was a Mexican immigrant in 1951. I came to the United States and settled in Houston. We were in an urban area in Houston.

I went to the local high school, junior high, elementary where I grew up. Consequently, I went to medical school and finished and then I returned to Houston t continue my medical practice in the neighborhood where I grew up. I've been there now for over two years, but in the area, I've been there almost twelve years.

It's been my understanding that—this, of course—let me make it clear. I am in an underserved, underprivileged neighborhood. It's called Magnolia. It's in the area of Harrisburg and 75th, near the ship channel. Here, I've been working with the community since almost one year ago. I finally purchased a clinic that's been there since 1929. I'm the third owner of the clinic. We've been very, very successful in trying to give medical care to the underserved and socially and economically impaired patients.

My main concern at this time, and, for the committee, I will be glad to give you a written statement later on, is the fact that we in the community take care of a lot of the Medicaid-Medicare patients. We have a lot of cash-paying patients because of the lack of insurance. We have 90 percent—95 percent of our patients are with no insurance at all.

This is a very trying situation for the community in itself. Unfortunately, in the communities like the one I serve, most of the physicians that have higher specialized medicine are not to be found in this area. Most of us are family practitioners. I am specialized in family practice. I did that here in Houston, in Baytown, actually. I was fortunate enough to come back and try and give what I know to the community.

But one of the things that concerns me and the community is—and this is for you to know—the fact that there are so many phar-

maceutical products out there now that are very expensive for our people. They're not able to really pay for this medication. We're having to try and use the older medications in the community that are much less expensive. They're not as sophisticated as the ones we have now.

We also have the problem with the fact that many of the patients are not—even though they have Medicaid, they're now being left without Medicaid. They're not being able to meet the standards of Medicaid. They're losing the Medicaid itself. We have a Magnolia Family Multi Center that's just four blocks from that clinic and this, of course, is overly worked. They're overly populated with patients.

We get a lot of the overspill. Unfortunately, we have—I myself have done many procedures that are just procedures that are normally left to specialists; for example, lacerations, cut tendons, things that usually have to be done in the emergency room section. We have these in our clinic where the risk is high for the physician, but you can't do anything because these people will just walk off, will get contaminated, will get infected, and come back with a higher problem.

Therefore, this is the kind of problem that we're facing today because of the lack of our actual health needs for the low and underprivileged. One of the things that I'm very concerned of, as well, is the fact that people will get medication. The medicine is given to them. They do not have the money to buy it. Sometimes they give them the medication. They take—they stretch it out. Instead of taking the medication for—if they need something chronic like for diabetes or for hypertension, et cetera, they run out of the medication. They think by taking half of the dosage, they can go further with it.

But as most people know in the medical community, the medication will not be effective unless it's a certain dosage, no matter how you stretch it. So you aren't really going to get the benefit. This is the kind of thing we're facing today, education to the patients, et cetera.

I could go on and on, but this is basically what I'd like to bring forward is the necessity of these areas of getting better and more facilities in order to provide just the minimum medical care to the community.

Mr. GREEN. Thank you, Doctor. Mr. Schaper, thank you for being here. We have one mike to share. A little cost-cutting in the Federal Government, I guess.

Mr. SCHAPER. I'm Robert Schaper, President and CEO of Tomball Regional Hospital and today representing the Texas Hospital Association. I've been a hospital CEO for 23 years and out of Tomball for about 18.

I'd like to thank you and Congressman Becerra for the opportunity to address the subcommittee on what I feel are critical issues regarding reforms to our Nation's health care delivery system. My message to the subcommittee boils down to two numbers; basically, 26 and eight.

According to the non-partisan researchers at the Employee Benefits Research Institute and based on 1990 census data trended toward 1994, 26 percent of the non-elderly population in Texas are

uninsured. Since 1990, the uninsured population in Texas has grown at an annual rate of at least eight percent.

Those numbers will continue to rise and the grief and fear families experience when they lose their health care benefits has leaped out of the low income population and it's now into America's middle class. It's effecting us all. America's hospitals and their emergency rooms provide a safety net or another safety net for the uninsured. Last year alone, Texas hospitals provided more than $2.7 billion in uncompensated care.

Obviously, we can't go on like this. Each dollar of uncompensated care must be shifted onto the bills of patients who still have insurance. Then the next year, their insurance cost skyrockets and they, too, may lose their coverage. So the vicious cycle of cost shifting is a major factor in the rising cost of health care.

To bring this more to a personal level, I've attached a letter to the document that you have. I won't go into the letter, but there are two points that are particularly interesting there. It's from our CPA firm of Ernst & Young and this is back in 1992. We analyzed in detail more cost shifting that effects just our hospital in Tomball.

There are two points there that I'd like to go over. Number one is our Medicare inpatient costs exceeded our payments from Medicare by $2.4 million or about $146 per Medicare patient day. The $2.4 million Medicare shortfall plus $4.5 million in uncompensated care or bad debts, whatever you want to call it, caused a cost shift, a total cost shift of $490 a patient day. In other words, if the hospital had been reimbursed equally from all patients, as this new health care reform plan proposes, then the patient charges could be reduced by 26.6 percent. That's a striking figure.

As a hospital administrator and on the front lines of the battle, I can't really tell you exactly how to draft legislation. I'm not sure there's an easy answer. And I know you face a tremendously complicated task in assembling a bill that Congress can pass and the public can pay for.

But I ask you to aim at the following goals because I feel strongly that we must meet each of them before we can put our system back on track. First and foremost, Congress must legislate and fund a system that covers every American. Universal coverage is absolutely essential if we ever hope to bring health care costs under control, and every survey shows the public will support it.

Secondly, I urge you to free the private sector from the needless regulations and give us the tools to build a delivery system that is fair and more efficient. In the hospital community, our voluntary efforts to streamline and consolidate have cut the rate of health care inflation in half this year and I think we can do more.

Managed care and capitation can work to keep health care costs affordable. I think particularly in the Houston and in the Texas area, capitation is just beginning to take hold. We're lagging behind some of the States.

Third, let's face the cost of what Americans want and pay our bills just as any family must. Full, fair funding of guaranteed health care coverage is essential. Medicare payment rates are so low that every time a Texas hospital admits a Medicare patient, we

lost $1,130 per case. If we don't provide the funding for the benefits we guarantee, the system cannot possibly succeed.

Whatever you do, don't force providers to continue the cost shifting that is the principal driving force behind the problems of American health care. If we can't find the money, then we need to cut the coat to fit our cloth.

Again, thank you for the opportunity to address the subcommittee and I'll be happy to answer questions later.

Mr. GREEN. Thank you. Dr. Rosenau?

Ms. ROSENAU. Thank you, Congressman Green, Congressman Becerra. Good afternoon to all of you, to those who are working with you on the subcommittee, and to all of the guests here.

My name is Dr. Pauline Rosenau and I'm an Associate Professor of Management Policy Sciences at the University of Texas Health Science Center. The Health Science Center has a medical school, dental school, biomedical sciences, allied health services and nursing school, and we're the only school public health in the State.

Our medical school is distinguished because we are—there are only four medical schools in the whole country of 125 that graduate a higher proportion of primary care physicians than we do, and we're very proud of this. We also provide $30 million in indigent health care each year, on the average.

We are located at the Texas Medical Center through six related opponent UT institutions, including four medical schools. We give $600 million of care, charity care, much of it to critically ill patients, and top quality care to boot.

My testimony today is on behalf of those academic health centers and academic medicine, in general. Potential for health care is very great. We're going to see some dramatic transformations in our delivery and payment of health services, no matter which health care reform bill you choose to bring forth and negotiate.

But uncertainty as to the future is something that is very frightening for all of us, those of us in academic medicine. We want to be sure that the quality is maintained, as well as, at the same time, containing costs. There's a general agreement even amongst the most sophisticated specialists that, yes, we do have to look at cost containment; that preventive care is essential; that we have to have more primary care physicians.

But at the same time, we have to worry about educating medical doctors for the future and all our health personnel. We have to worry about health services in general for the future and if we let up on biomedical research, we'll be in a situation of the status quo for many years to come.

Up until now, we really have some of the top health care in the country, in the world, for that matter, and what we would like to ask is that you pay a little bit of attention to our concerns when you're trying to cut the costs. It costs more to run a hospital where you're doing training, where you're training medical personnel, just by the fact that you are teaching, than it does to run another kind of hospital.

The problem is that many of the networks of providers and many of the new plans will hesitate to contract with these training institutions and the cutting-edge research institutions because they're

going to have to charge more. If that happens, we'll see that quality is sacrificed in the long run, if not in the short term.

Some of the health plans before you do take this into account. The Health Security Act has two or three provisions which would require that plans contract with specialty organizations, such as Baylor and the Anderson University of Texas Medical Centers institutions.

On the other hand, many people working in those institutions are unconvinced that this is sufficient or they worry that these parts of the bill will drop out in the long run. So I did want to alert you to that. Some of the other bills before you don't take health science centers and academic medicine into account in any way, and these are especially worrisome, because we know that the congressman that drafted these pieces of legislation didn't even give a second thought to health science centers and academic medicine.

The final concern is with regard to time. Even if we agree on the basic goals, it's very difficult to change the curriculum overnight or to revise an institution's purpose and goals, which, in the past, has been to train specialists, largely, in many cases. So we ask that you do keep in mind the timeframe that we're working in and give us the time sufficient to revise those goals and purposes.

There are top quality people out there, have been in the past working to train doctors and nurses. I think it's important that they continue to have the tools to do so in the future. Anything you can do to make that transition easier would be very much appreciated.

Thank you for your time today.

Mr. GREEN. Thank you, Doctor. I just have a couple of questions. It seems like we spend hours and hours, because so often in Washington, we hear from people who are not so directly involved in health care.

Dr. Guerrero, you and I have visited over the last few months about the east end. Of course, it can be in Northside or LA or New York or anywhere else. The percentage you gave us is 95 percent of the patients in your clinic at 75th and Harrisburg do not have insurance.

Dr. GUERRERO. That is correct.

Mr. GREEN. And you think a lot of that is overflow from the Magnolia Multipurpose Center and the Harris County Hospital District Clinic.

Dr. GUERRERO. I think a lot of—yes, it's overflow, but I think a lot also is the community is in much need. As you know, we've built within just a two mile radius of that area—there have been at least four new elementary schools just put out in the last 1½ or 2 years. It's something that you don't see in many communities because it's just an overinflux of patients.

One of the things that I think has a big influence on this situation is the new amnesty program that was placed in full blown line several years back. This has given instant citizenship and instant migrating status to hundreds and thousands of people in areas of this nature and this has brought on also a big heavy overflow of patients. It's a very concerning problem.

Mr. GREEN. What is the percentage of Medicare patients, for example, that you would have in that area? If 95 percent are not in-

surance or private insurance, do you have the numbers for Medicare patients or for Medicaid patients that you would have?

Dr. GUERRERO. Yes. Medicare patients are approximately 30 to 35 percent. Medicaid is about 50 percent, 55 percent, and the rest is cash-paying. Only about maybe five percent are just with some sort of insurance.

Mr. GREEN. Some sort of employer-based insurance.

Dr. GUERRERO. That is correct.

Mr. GREEN. Thank you, Doctor. Dr. Rosenau, I have—of course, having served in the legislature for a number of years, I know the University of Texas Health Science Center and the quality that can be provided. I know this panel is so unusual. We have a suburban hospital in Tomball and in the Medical Center, one of the finest in the world, and a physician and also a chief of staff at a for-profit hospital, from what I understand.

So we have a varying group here that serves our community. The concern I've heard from my own district is there are often people who cannot access the health care system. If you could just talk to us a little bit—I know the University of Texas provides indigent care for people who can't through hospitals. If you could, just elaborate on that just a little bit on how you provide it in the community. I know through hospital district and sometimes through different hospitals.

Ms. ROSENAU. Each of the different elements provides different services. There is the emergency room, where everybody is taken care of no matter what they're condition, which costs an enormous amount of money. And any kind of health care reform—many of the major bills will, indeed, give some alleviation by making care available to everyone and then you won't have people who don't have insurance. Everyone will have insurance when it comes to emergency room care.

We provide consultants, research assistants. Many of those being trained go to outlying clinics. It's just an enormous range of services. I'm now participating in an effort by 15 local Harris County hospitals to find out what are the unmet medical needs in these geographical areas and the hospitals are working together to provide a research fund so that we can go out and interview people in the community.

This is part of the disproportionate sharing program. The hospitals have to do research on these topics and we're taking up the slack and doing it for them, but in a more comprehensive way to give them better feedback.

So these educational institutions impact on almost every dimension of health care and health services.

Mr. GREEN. Mr. Schaper, I want to thank you for your testimony and the statement from the Hospital Association. You serve anyone who comes to your emergency room. You are required by law. Whether you're the richest or the poorest, if someone shows up at Tomball Regional Medical Center, you serve them in the emergency room. Is that correct?

Mr. SCHAPER. That's right. I think it should be understood that a lot of times we say that there's 38 million population out there that's underserved or not served by insurance right now. That doesn't necessarily mean that it's going to be $38 million or 38 mil-

lion people that you're going to have to pay for that's not currently being paid for now.

You've heard the old commercial pay me now or pay me later. Well, unfortunately, a lot of these patients end up in the emergency room and the cost of taking care of them by the time they get there is much, much higher after they've let their sickness or illness go on for two or three weeks than it would be had they been taken care of on the front end.

So there probably will be some actual cost savings when everyone has access to health insurance. So, yes, in Texas, we actually had the State law before the Federal laws for seeing every patient in the emergency room. I think we all do that.

Mr. GREEN. Let me give you an example and somebody in this room may have been at our town hall meetings and heard about it, and Dr. Guerrero pointed it out, someone who may be a diabetic who waits until they're actually in an emergency and then shows up at the hospital instead of getting preventive care and also taking care of themselves.

It's a good example of the cost of providing care for someone's diabetes later on is much more if it's not monitored earlier.

Mr. SCHAPER. Yes. I think the doctor probably could address that a lot easier, but absolutely. That was my point about pay me now or pay me later. We sometimes see the patient after they've gone so far that the cost of taking care of them, not to mention the cost in the emergency room, is many more times higher than it would be had they been able to go to the doctor's office two or three weeks earlier to get taken care of properly.

Mr. GREEN. Congressman Becerra.

Mr. BECERRA. Thank you. Actually, I have several questions, but I'll see if I can run through these quickly and I would appreciate it if the witnesses would try to keep their answers succinct, as well. Let me, Mr. Schaper, continue with this, because my wife happens to be an OB/GYN at the county facility that I mentioned in Los Angeles.

She always speaks to me about the situation where a baby comes in—a mother comes in to deliver a baby. The baby has some problem with it. The baby goes into a neonatal intensive care unit. We pay, in the public hospital, to a woman who is indigent who obviously will not be able to pay for the entire cost of the medical stay, between $2,000 to $5,000 a day, depending on how severe the problem is for the child and if the child has to stay in an incubator and so forth, whereas if we had provided nine months of prenatal care, we probably would have paid for it with just one day's worth of stay in a neonatal intensive care unit.

Oftentimes these are babies who are born maybe a month premature. So they may have to be there three weeks to four weeks. The whole idea of prevention versus remediation and the fact that we are paying, all of us, for some of the care that the people that are uninsured are receiving because they can't afford to pay for the entire bill going to an emergency room, how do we get that message across to people who believe that if we do anything to tinker with our current medical system, we're going to tax them to death?

Mr. SCHAPER. I'm not sure. The way in which we've been able to finance the health care system in the past has really been inad-

equate and confusing. I'm not sure how you'd do that. It's absolutely true, though, that it's not going to cost near as much as people think that it will. I don't have the answer.

Mr. BECERRA. Do you think that folks within the hospital community, the providers, have been out there as vocally as they could be explaining to people what the situation is? I think you did a very eloquent job right now of explaining that we may have 38 million people who are underinsured, but yet they do access the system, because we don't let anyone in this society die. So we let them make use of the emergency room, but, obviously, at a cost that's much greater than had we provided them with basic preventative care up front.

Let me cite one other example. I suspect everybody in this room could talk about their personal experiences. My mother was in the hospital for some calcification in her ear, which was causing her hearing problems. She was in the hospital for less than 24 hours. She got home with a $13,000 bill. Part of the bill, when we looked through it, was $5 for an aspirin tablet.

Now, let me ask you something that I think is more difficult for folks in the hospital profession to answer. Cost controls. When I take a look at a $5 charge for one aspirin tablet when I know I could have gone to the pharmacy and bought my mother a hundred tablets for about $4, why should we not, as a Nation, be demanding that there be some type of control on the amount that hospitals and doctors can charge for a service or a product?

Mr. SCHAPER. There, again, that goes back to the way we've been forced to bill for our services here. Let's take—I'm not sure if your mother was Medicare or not.

Mr. BECERRA. No, she wasn't.

Mr. SCHAPER. My mother was a Medicare patient that was in the hospital last year and she died, unfortunately, but her total bill for the two-month stay was like $227,000. But under the DRG system payment, the hospital received, I think, $23,000 or $24,000. There were a lot of $5 aspirin and things on there, but that wasn't the true figure that the hospital received.

As I said earlier, in this cost-shifting thing, that's where these $5 aspirin come from, to pick up the shortfall in not only the Medicare losses, but also in the emergency room uncompensated care and the other things that we're doing.

We're paying for it now with the system that—I'm not sure how we explain to people that it's not really that much of a reform to what we're actually doing.

Mr. BECERRA. You hit on what I think are two essential points. One, where you already provide care to people who are uninsured, it's just emergency care and it's the most expensive type of care. So that makes us pay right now more than we should for health care. But, two, what you mentioned right now, the cost shifting, which is the uncompensated care.

My mother was paying $5 for an aspirin tablet because she, because she's insured, is paying for part of the cost of those who don't have insurance who end up going to the emergency room.

I also saw a report on one of the network television stations that a woman who went to the hospital paid $17.50 for a quart of bottled water. Now, when you think about that, we can go out to the

store right now and buy a quart, not a gallon, a quart of bottled water for under a dollar.

I would hope that those who are in the health care profession would just do a better job of doing what you just did, explaining to people that we are already paying, because what I always encounter when I talked to the constituents in my district is that they say, Congressman, we'd love to have health care reform and we want to see those 38 million people provided with insurance, but I don't want to be taxed to death.

I try to explain to them you're already paying the taxes. It's just not called taxes. It's called uncompensated care and it's emergency room care. I would hope that the folks out there in the health care profession could do a better job of conveying that.

Let me move on, because I'm running out of time and I have so many questions. Dr. Guerrero, let me ask you something. I don't know if you've had a chance to really examine closely the Clinton proposal, the President's proposal on health care reform, but Ms. Richardson brought up the point about the essential community providers that would be given special designation to help take care of those that are underserved, the indigent, those in rural communities or those in poor urban communities.

If you've had a chance to examine that component of the President's plan, does that address your concerns satisfactorily?

Mr. GUERRERO. No.

Mr. BECERRA. Okay. Why not?

Dr. GUERRERO. Because I think, first of all, the plan that—and I have been looking at President Clinton's plan and it's very good. I think it's something that's been forthcoming for many years. It's, I think, about 20 years too late, but it's never too late, at the same time.

I think that one of the things that concerns me is the fact that the primary care situation, primary care providers, physicians, family physicians and general practitioners, internists that are doing primary care, is the number one problem that we have. You can have the best plan in the world and anybody's plan can be out there, but if you don't have the family practitioner, the primary care physician out there to handle this load, we're going to be spinning our wheels.

By the year 2000, we're going to need another 25,000 to 30,000 family practitioners which we are not going to have. I think one of the things that we can do as family practitioners, which concerns me a lot and you hit upon it earlier, is preventive care. We go back to what Congressman Green was saying about diabetes.

Diabetes is one of the worst diseases that harbors because it goes on and on for years and years and it affects so many organ systems, your heart, your kidneys, your brain, your muscles, everything, your liver, everything is affected when it's out of control. We have so many people out there out of control. We need to have diabetic centers. We need to have well baby centers to prevent those complications. The well prenatal centers. Just by educating many of the families on food and so forth can just prevent some of these things, these disasters of children being born prematurely and spending months and months in high intensive care units, running up bills in hospitals.

I think that the plan is good if we have—and we try and convince the medical students of today that the way of the future is a family practitioner and primary care, and I think that can help a whole lot. Specializing and subspecializing is good and it's good for technology, but in the future, it's going to hurt us more than the primary care, because preventive medicine is the way you're going to control all this.

That's how I see it.

Mr. BECERRA. Congressman Green, I hope you'll indulge me. I just don't want to let these folks go. They gave some good testimony.

Let me ask you, Dr. Guerrero, how do you feel as a private practitioner, fee-for-service based, with a clinic, how do you feel you will be able to survive with an alliance type system? Do you think that that takes care of your concerns as a small provider compared to, say, the Kaisers, the big HMOs? Will you be able to compete with the big guys?

Dr. GUERRERO. Yes. I think we will be, basically because—I'm talking in my own personal medical practice. I'm going to find that in my practice, for instance, having 90–95 percent of the people not covered which all of a sudden will be covered, we're going to need many more, in my community, in my area, physicians to cover this need. I will be okay.

It's the physician that's sitting up in the medical center with—he's specializing in thyroid problems with 10-year-olds and 20-year-olds. This is the kind of thing that's going to be affecting the physician. That's why I'm saying in my own perspective, I think it's going to be a very good thing. I'm going to be very happy because I'm coming back to my grassroots community where I grew up and I've seen now that many patients don't have any kind of medical coverage will now have it, and we're going to be needing more people and more physicians in that area.

I have no problem. I'm going to be able to really blend in well with that.

Mr. BECERRA. Thank you. Let me move on to Dr. Rosenau. Before I do that, though, I want to make sure I point out to Dr. Guerrero that you mentioned the amnesty residents, the immigrants who came in and qualified for amnesty. I never like to let the impression be left that the immigrants are costing us more than what they really are.

For one thing, the Federal Government has taken on the task of reimbursing any medical provider for any costs of the—there are about three million people that qualified for amnesty and now actually have a chance to become U.S. citizens after five years.

But the Federal Government has been and will continue to reimburse any State for any medical costs resulting from those amnesty applicants who will now qualify as permanent residents. Now, the problem is after five years, they become part of the system within the State, but I suspect you're going to find that most of these folks have been working, because for the five years that they've been here, they have not been entitled to any public benefits whatsoever.

So I just hate to leave the impression. Especially in my State of California, there's such an anti-immigrant feeling that I think it's appalling and I think it's shameful that we think that immigrants

come in only to consume services when, in fact, we know that they contribute so much to the economy.

Let me, Dr. Rosenau, ask you a couple of questions. I'm glad the panel touched on the whole issue of prevention. A couple of questions. Teaching hospitals, LA County also happens to be a teaching facility because it's affiliated with USC, University of Southern California.

The concern there is the same as what you raised. How will we survive not only with the old facility that we have to deal with, older equipment and so forth, but, at the same time, we have higher overhead because we are, at the same time, training the people who are out there becoming the physicians.

What do you say we should be doing to try to make sure that we do preserve our teaching facilities and also have them focus on graduating folks who focus on prevention, like the primary care physician versus the specialist?

Ms. ROSENAU. There are a number of provisions already in the Health Security Act. They require that plans, which Dr. Guerrero will have to negotiate with in order to be able to serve those people who live where his office is today, at least in good part, those plans will have to contract with specialty institutions. That's already been foreseen, that possibility.

The alliances are going to be required to pay 1.5 percent, under the Health Security Act, to the training hospitals and other institutions of that nature for medical education. I think those are good provisions.

Some people say, well, we really can't calculate what that will turn out to be in advance. That's true and I think as we get further into the process of legislation and we are clearer about what the revenues of the alliances will be, it might be easier to get a better estimate and having those published and made available will be comforting to those who work in those kinds of institutions.

But what people worry about mostly at the moment is the uncertainty. There is an environment in academic medicine at the moment which I guess can only be characterized as that of making people susceptible to exaggeration hyperbole.

My feeling is that change and the fear of the uncertain in the process of change is often much greater than the actual implementation, which is, for the most part, routine. But there is an atmosphere that's very worrisome at the moment and as soon as you can modify that environment by making the various parameters clearer to everybody concerned, the better it will be for all of us.

Mr. BECERRA. And I will leave it at this second part of the question about how we ensure we have the right types of providers graduating from our schools, our health schools. I know that in California about 40 years ago, for every two primary care physicians, family doctors, we were graduating one specialist. Now, it's for every two primary care physicians that we graduate, we graduating four specialists.

How do we change that so we get back to graduating a lot of folks who will go out there and service the community up front and not wait to make all the big bucks as specialists doing the real—the dermatologists and all those kinds of things that really don't help us up front?

the dermatologists and all those kinds of things that really don't help us up front?

Ms. ROSENAU. I think you have to—from the lessons that we've learned from other countries, as well as from the experience with places such as where I work, the Health Science Center at the University of Texas. I think we have 55 percent primary care physicians in our graduating classes.

That's an outstanding record; as I said, better than 95 percent of all the other medical institutions. But if there were some provision to pay primary care physicians better. And it's hard to justify salaries up to a million dollars for thoracic surgeons when they may not do that many operations anymore because of the new technology which makes it possible to do exploratory surgery in advance by just doing an MRI.

I think what we have to do is just take a better look at the compensation patterns and to begin to appreciate the primary care physician; not just terms of words, but in terms of financial incentives.

Mr. BECERRA. Thank you. Thank you, Congressman Green, for indulging me some extra time.

Mr. GREEN. Thank you. I have, like I said, lots of other questions for both this panel and also Ms. Richardson will be available. A lot of times, we'll send a written request for information or to expand on it, because, again, we're always limited on time. We'd like to hear from lots of other people today. Thank each of you for being here and sharing with us. It's been a great panel.

Our next panel, if they would come up, are Mary Walker, Houston Regional Director of the AARP; Jane Nerison, Manager of Compensation and Benefits from Lyondell Petrochemical Company; and, also, Joyce Gilliam, owner of Fiesta Loma Linda Mexican Restaurant in Houston.

This panel is from senior citizens, AARP, but also from a large employer and also a small employer, because whatever plan actually ends up passing, it's going to have an impact on the large employer who may provide coverage now and also on the small employer who may or may not provide it now because of the cost, and that's what I wanted to make sure we got into the record, the testimony from both sides of the employers, but also from AARP and Ms. Walker representing senior citizens.

Ms. Walker, welcome.

STATEMENTS OF MARY WALKER, HOUSTON REGIONAL DIRECTOR, AARP, KATY, TEXAS; JANE NERISON, MANAGER, COMPENSATION AND BENEFITS, LYONDELL PETROCHEMICAL COMPANY, HOUSTON, TEXAS; AND JOYCE GILLIAM, OWNER, FIESTA LOMA LINDA MEXICAN RESTAURANT, HOUSTON, TEXAS

Ms. WALKER. Thank you, Mr. Chairman. I am Mary Walker, the AARP Voter Regional Coordinator for the Houston Metro Region. That includes Congressional Districts 7, 8, 9, 18, 22, 25, and your Congressional District, 29.

You might realize that this is the largest one in the United States. So we do control a lot of voters.

Mr. GREEN. I thought I had a large constituency.

Ms. WALKER. There are 1.2 million registered voters in Harris County alone. That's a staggering figure. Percentagewise, the seniors is the largest voting segment. Thank you for inviting me to testify before the subcommittee today.

AARP is committed to the enactment of comprehensive health care reform in 1994. True reform must assure health care coverage for every American, a comprehensive benefits package that includes prescription drugs and long-term care, and systemwide cost containment that makes coverage affordable for all.

These three objectives are essential for good health policy and sound economic policy. I would like to focus today on one aspect of health care reform that is on the minds of older Americans and their families and that is critical to our support for health care reform.

That is long-term care. Most of us have personal experience, friends or family who have had to cope with the financial, physical and emotional stresses involved in meeting long-term care needs. As policymakers, it's natural for you to translate the subject into a vision of Federal budget dollar signs. Our families also see dollar signs. They see huge dollar signs when they struggle to pay for home care for a child, a spouse or a parent, while still dealing with college tuition costs and a home mortgage.

Caregivers, most often daughters, spouses and mothers, see not only the direct costs of giving care, but also the income they lose both now and in their future. Caregivers often forgo higher paying job opportunities. They work part-time or give up their jobs altogether.

Each of these decisions means less income now and less pension and social security income in the future. The government also pays in lost tax revenue and higher assistance costs later. Health care coverage for acute illness alone will not give families real security and peace of mind. For families, there is no difference between spending $20,000 on home care and spending $20,000 on hospital care. It's still $20,000 they do not have.

The President's proposal for a new home and community-based care program recognizes that few families can afford the cost of long-term care. It also recognizes that the need for long-term care extends to all age groups, a child born with a developmental disability, an auto accident victim at mid-life, or a parent with Alzheimer's disease.

Appropriately, the proposal focuses eligibility on measures of disability, not age or income. It would give persons of all generations new choices and address the current system's institutional bias by helping families to avoid having to place loved ones in nursing homes.

The President's home and community-based care proposal also would be good for our Nation's economy by creating approximately one million new jobs, providing assistance to working caregivers, and helping some disabled persons to become productive, taxpaying members of society.

There are a number of areas in which the proposal could be strengthened; stronger incentives to be created to encourage space to participate in the program. While we agree that there is merit and State administration of a home and community-based program,

In addition, the reliability of funding within the program's proposed caps should be improved to include some margin for error and to reflect certain limited cost increases that are beyond the control of the States. Although we are pleased to see even the small Medicaid nursing home coverage improvements, millions would remain vulnerable for bankruptcy due to expensive nursing home costs.

Studies show that people's greatest fear is impoverishment from nursing home costs, which now average $30,000 a year and can exceed $60,000. It is important to clarify that the President's long-term care proposal is not a new entitlement program. It's still a vast improvement over our current non-system.

The President has made an important far-reaching start towards achieving security against the overwhelming human cost of long-term care. Since it does not, however, meet the full extent of the need for long-term care, we should not attempt to oversell the proposal.

However, the President's statement in his State of the Union Address that the American public is way ahead of the politicians on the issue of health care reform is instructive. We believe this to be particularly true for long-term care. The findings from each of the four surveys we have had an independent firm conduct between April of 1993 and January of 1994 all show that public support for health care reform increases dramatically when long-term care coverage is included.

In conclusion, Mr. Chairman, AARP commends the President and members on both sides of the aisle who have brought the debate to this stage. As we go forward, we ask you to always consider the cost to American families of not including long-term care in health care reform.

The President's home and community-based care proposal can begin to provide greater security and protection now and a solid foundation for the future. There's one thing we must all agree on. The status quo is not an acceptable option. AARP looks forward to working with the members of the subcommittee to ensure that long-term care remains an integral part of health care reform.

Thank you.

Mr. GREEN. Thank you, Ms. Walker. Ms. Nerison, welcome. I notice from your testimony that Lyondell—and for those who are here, Lyondell—anybody who has ever gone out I225, it started as Sinclair, then Arco, and now Lyondell. So it is a large employer all over the district. Thank you.

Ms. NERISON. Thank you. My name is Jane Nerison. I am representing Lyondell Petrochemical Company here today. Lyondell, as Congressman Green pointed out, has a large presence in Houston. We are a $4 billion integrated manufacturer and marketer of petrochemicals and refined petroleum products. We employ approximately 2,400 employees, with 99.9 percent of those employees located in the Houston area.

Our benefits package includes the provision of comprehensive medical benefits. This benefit is one that we have found to be most valued by employees. Accordingly, we strongly desire to maintain the ability to design, maintain and fund a competitive medical plan program that continues to meet employees' needs.

the ability to design, maintain and fund a competitive medical plan program that continues to meet employees' needs.

Coverage is offered to all full-time and part-time employees and retirees and their dependents. Participation in the plan is not mandatory. We do not impose any preexisting limitations on employees who enroll when they are first eligible or during open enrollment. We self-insure our medical benefits and require employee contributions of approximately 20 percent of the expected cost.

We are concerned about the cost of medical benefits and are addressing that issue. In order to better manage our costs while continuing to offer our employees attractive, affordable medical coverage, we are in the process of moving to a form of managed care that we believe should yield us savings of at least 10 percent in the first year.

After payment of required employment taxes, medical benefits are the company's most expensive benefit. In the past five years, our spending on health care has increased an average of 15 percent per year. Our cost per employee for medical benefits is approximately 20 percent above the national average.

We believe that the best way to hold down medical costs is through encouraging employees to be efficient and responsible users of health care services and by encouraging competition in the marketplace. In the current debate, there are a number of matters that concern us and that we would ask our representatives to take into consideration as they consider health care reform.

Generally, we do not support government-mandated programs. We believe that companies such as ours would be penalized by increased regulations, participation in mandatory programs, and a higher cost for being a good employer. We believe that Congress should focus on setting policy, removing barriers and equitably distributing the cost of the program among all taxpayers.

The creation of new or additional layers of Federal bureaucracy are unlikely to streamline, reduce costs or add efficiency to health care delivery. We believe that it is citizens, employers and the health care industry's responsibility to determine through market forces the most efficient way to achieve implementation of the policy.

We have concerns about the creation of the regional health alliances or HIPCs. We believe that they will add costs to the system and that an administrative nightmare will be created through trying to track employees' elections and company contributions thereto.

Although invited here today as a representative of a large employer, under the Clinton proposal, we would not qualify as an employer large enough to offer our own medical plan design. Being able to continue to do this is very important to us. In addition, we are concerned that the proposed rules permitting individual company plans are designed to be a disincentive for any employer to do so.

Thank you for inviting us here today to talk about this issue.

Mr. GREEN. Ms. Gilliam, welcome. I'm glad you moved because that speaker was probably a little loud on you.

Ms. GILLIAM. I am Joyce Gilliam and my husband and I do own a small restaurant in the east side. Gene Green is one of our neigh-

bors there in the neighborhood. I do appreciate you having this opportunity for people to really come and say what they are hearing from the public.

I was given very short notice of this meeting, so I feel like I'm not really well prepared. These ladies have done a wonderful job in submitting the facts. The other employer representative covered a lot of bases that I would do, so I'm not going to repeat those things.

In our restaurant, we're in the middle of the east side, which is basically an industrial area. A lot of our patrons are small business owners. So we have been getting a lot of feedback from them. So I'm just going to sort of bring forth some of their comments that we've been hearing over the last month or so.

It seems to be that a lot of the small business people, they really realize that a lot of their employment, even though they each one hire perhaps 50 or less employees, you add up all those small businesses, and we're a very important faction in the economy in that we do hire a lot of people; each one separately, but each one bearing their own burdens of taxation and so forth.

So many of the small business people are really concerned about this because they feel like it's another burden to their expenses, their overall expenses. They almost feel like we're being taxed unfairly because of the smallness of a company that's, say, less than 50 employees. It's going to be another burden to operations.

We do have so many things coming online, things to do with readjusting our building and things like this, to do with the handicapped and a lot of other things that have come online in the last year or so, and these have been burdens, but we've faced them and we've overcome them and now we're looking at another cost of our operations.

We don't want to have to go up on our prices, but this is what will happen. These costs will be handed on to the consumers. So it's just kind of like it's a merry-go-round. We just keep adding costs and costs and costs.

So that seems to be the feedback that we get from a lot of the small business owners. So, basically, as well as the things that she's already covered, they apply to the small business person, too. So that's basically all I had to say, is that the added burden is just really going to be a problem for small business people.

Mr. GREEN. Thank you, Ms. Gilliam. How many employees do you have?

Ms. GILLIAM. Ourselves, at our restaurant, we have like 20.

Mr. GREEN. Twenty employees. And are they full-time?

Ms. GILLIAM. Off and on. Some are full-time and we have a lot of part-time people.

Mr. GREEN. How many do you think work more than 32 hours a week or as many as 40 hours a week?

Ms. GILLIAM. They nearly all work 40 hours.

Ms. GREEN. They all work 40.

Ms. GILLIAM. Yes.

Ms. GREEN. Have you priced—tried to get quotes from insurance to provide it for employees?

Ms. GILLIAM. We have tried over the years to provide something like this and the employees just say—they don't want to participate

in it. So many of the employees of our gender, our type thing, they can go to the human services type things and get what they need. They don't need this other.

Mr. GREEN. So they're already accessing health care. They may go to a clinic.

Ms. GILLIAM. Correct. And so many of the small manufacturing facilities in the east side use—this is the type thing that they're into. So this would sort of be duplicating or I don't know how it would be—how they would adjust to it.

Mr. GREEN. And I know you're in a different business. I had a constituent who owns a flower shop in east end Houston and he complained to me a couple months ago—because it's a very competitive business. It's not too far from Forest Park Cemetery. He said we're competitive because of weddings, funerals, what have you, and he provided insurance for his three employees and he said but my closest competitor two blocks away doesn't.

He said I'm going to have to drop it because I can't continue to afford the over 20 percent increases every year that he was seeing. He said unless you do something about it, my three employees are going to go the way of the other ones that are not covered, whether it be by social services or something, because we're paying for the social services, I guess, one way or the other, through your hospital district taxes or through something else.

That's the hard response that—because some small businesses provide it and some don't because of the costs. I know the President's plan has a cap on payroll of the 4.9 and we're still trying to see if that would—how that would apply to someone with 20 employees.

I know most of the time when Congress has provided additional benefits, there are exceptions even in minimum wage law that we know for entertainment and things like that. So there may be some exceptions, and, yet, by and large, people pay minimum wage, with a few exceptions that are there.

I think whatever passes has to be crafted that we don't see businesses like yours, whether it be a restaurant or retail or someone—and, yet, your employees still have coverage. And if your employees have that coverage, then that's fine. If there's not a problem, we don't need to fix it.

Ms. GILLIAM. But a lot of people in the small businesses are concerned with if they're told they have to do this, it's not a choice. This is not a choice. In America, we were always led to believe that we could rather run our businesses the way we chose to as long as it was not harmful to anyone.

Mr. GREEN. It's fair. We have, like I said, minimum wage laws. We have wage and hour laws. The government, all levels of government, even the City of Houston, tells you what you can do, all the way up to the Federal Government. So we have some restrictions.

Ms. GILLIAM. Right. But the thing is whenever we encounter more costs, then we have to pass them on to the consumer. There you go. This ends up costing somebody more.

Mr. GREEN. Thank you, Ms. Gilliam. Ms. Nerison, the insurance package that you offer that your employees pay 20 percent, is that dependent care and employee?

Ms. NERISON. That package includes dependents and the employee and we reimburse—we ask them to reimburse 20 percent for family coverage and 20 percent if they're only taking single coverage.

Mr. GREEN. From what I understand——

Ms. NERISON. It was heavily subsidized.

Mr. GREEN. [continuing] of the President's plan, it would be a 20—the President's plan would require 20 percent or no more than 20 percent employee participation and 80 percent employer. I've been told those numbers are not hard and fast, because I know some large employers that provide it 50/50, for example, or 60/40. But they would have some type of access to that.

Also, I know you mentioned, even though you're what I consider a large employer, you don't quite make that 5,000 cut, but we heard Secretary Bentsen mention that that is another number that's flexible that they may lower it 500, I even heard, which would obviously cover you, but wouldn't cover Ms. Gilliam by any means.

I appreciate your testimony.

Ms. NERISON. Thank you.

Mr. GREEN. Congressman Becerra.

Mr. BECERRA. Thank you. Ms. Walker, let me begin with you. Again, I have tons of questions. I want to thank you for putting on the record that we will have the fact that there is such a dire need for long-term care and that it's essential that it be a component of any plan we come up with. I think if we were to come up with any plan and leave out long-term care, I think we've done everyone a disservice, because ultimately we will need some form of long-term care.

Let me ask you a particular question, though. You are now Congresswoman Walker.

Ms. WALKER. Well, not really.

Mr. BECERRA. Yes, you are. Today, for the next few minutes, you are Congresswoman Walker. I am one of your constituents and I am, as I am, 36 years of age. I have a family, I have a daughter, so it's a family of three. I right now pay for my insurance. I come up to you and I say, Congresswoman, how are we going to pay for this long-term care, which I hear is extremely expensive and could go on for many, many years.

I right now am paying enough for my health care. Are you telling me you're going to raise my taxes in order to pay for that long-term care or what are you going to do?

Ms. WALKER. No, I'm not telling you I'm going to raise your taxes. I'm telling you that we cannot afford to stay status quo. We, as senior citizens, and I am a Medicare person, have been for a few years, we will benefit probably the least. It is the baby boomers—you're just under the baby boomers, because my children are baby boomers. They are the ones that should be concerned about health care reform as much as anything else.

Another thing I want to say—and we always think—I've talked to AARP chapters. When we think of long-term care, we think about the nursing home. I have a daughter. She probably would take care of me. My last hope and never desire is to go to a nursing home, because I'm also a member of Texas for Improvement of

Nursing Homes. So I know how they operate here in Houston. That's another story.

But long-term care also makes it possible for us to remain in our homes with some care if we need it. Now, my mother is 93 last October and lives in Denver in a house. She luckily has good enough health she doesn't have to have this. But it is such a wonderful thing that she can stay in her own home, not even have to go to an apartment.

I intend to be 100 years old, because I had a grandfather 101 who wore out, nothing organically the matter with him. I'm going to do the same thing. So I call myself a recycled teenager.

Really and truly, we cannot afford not to have health care reform. I have made two trips to the emergency room this past year, one in Washington, DC at--

Mr. BECERRA. Lobbied too hard, I bet.

Ms. WALKER. No. I was at the inaugural party. It was too big a crowd. Everyone said I was chasing Willie Nelson. Not really. But I will say I did not get one single bill. Medicare took care of everything, because that was the type of hospital it was.

I went to a west side hospital here for a very small thing that happened on a Sunday and I couldn't get hold of a doctor. I couldn't walk, period. I was panicky almost. I happen to have a high deductible supplemental policy. I paid all that above Medicare and that portion that was somebody else's bill, too, because I put down that I had a supplemental policy. I still was under my deductible.

So when you talk about Medicare and a supplemental policy and so forth, you've got to look at it all the way and what it's going to cost. Let me tell you what, Congressman. I have people coming to me and calling me every day saying my doctor will no longer take Medicare people. This is a big problem. They've had that doctor 15 years and he's no longer going to take Medicare people.

I got a flu shot. They said Medicare would pay for it. Now, luckily, I could pay for mine without worrying too much, but when I went to my doctor, it was $20 and Medicare reimbursed me $7 and something. Now, that's not a lot of money and they didn't hurt me, but think of the person that it did hurt out there.

Medicare didn't cover our flu shots. There's a lot of things that I know firsthand with working with people. Our doctors are putting down there that we need all these different tests. Now, you say what do I care, somebody else is paying for it. Hey, that's got to stop. That's got to stop.

Do you know that that goes on your record that your doctor put down there and you needed that kind of a test? Do you know what happens when you go for a different supplemental policy because this last one has gotten too expensive?

Mr. BECERRA. Tell me.

Ms. WALKER. They have it that that was the matter with you. I didn't have anything the matter with me. I had bone density tests. I had all these other tests. And I kept saying, well, what am I doing this for? Well, next year you'll come back and you'll get another one and we can see whether you've lost any bone density. I said forget it, I won't be back.

Mr. BECERRA. I thank you for raising it. I know AARP has done a tremendous job of raising the issue of long-term care. I think

most people forget we're not only trying to raise an issue which will ultimately save us money and is cost-effective, but at the same time, we're preserving the family unit, which is something we always talk about, never doing anymore, yet this is a way to really preserve the family unit, but, more importantly, preserve the family unit with dignity and not make——

Ms. WALKER. That's exactly what I mean.

Mr. BECERRA. And not make someone have to go off to a nursing home when it's not necessary, when there's actually a family member who would love to be able to take care, but can't absorb the financial cost on his or her own. So I thank you for that.

Ms. WALKER. You're welcome.

Mr. BECERRA. Let me focus on the two individuals who have spoken from the perspective of the employer. Ms. Gilliam, if I can begin with you, because I suspect that most of us—I know I am, in particular, troubled by what will happen to businesses, small businesses, because in my district, I perhaps have more of the Gilliams of the world than I have of anything else. I don't have a lot of large employers in my district.

I'm very concerned that with our times the way they are right now, so tough, that we will instead cause a few people to go out of business and perhaps more than a few. But one of these that I always want to verify are the numbers, because when you look at the numbers that are there under the Clinton proposal, that's received pretty good and it's just a matter of finding out if, in fact, what the numbers under the plan show, the Clinton plan, really stand up to the test of reality.

So let me make sure we can do something and just, again, indulge some time here. You have about how many employees?

Ms. GILLIAM. Twenty.

Mr. BECERRA. Are you yourself insured, by the way

Ms. GILLIAM. I have a high deductible, like she talked about, but that—it's just for catastrophic occasions. It's like $5,000 deductible.

Mr. BECERRA. So for your family, no one really has a very comprehensive health care plan.

Ms. GILLIAM. That's correct.

Mr. BECERRA. So you will suffer from the same malady anyone else will in having a high deductible and so forth.

Ms. GILLIAM. Correct.

Mr. BECERRA. So you have about 20 employees. Some of them are full-time and some are part-time, right?

Ms. GILLIAM. Correct.

Mr. BECERRA. It's a mix. More full-time or more part-time?

Ms. GILLIAM. Full.

Mr. BECERRA. What would you say is the average wage of your employees?

Ms. GILLIAM. Average——

Mr. BECERRA. For the year.

Ms. GILLIAM. I'd just have to give you an hour.

Mr. BECERRA. Okay.

Ms. GILLIAM. Average is probably $6 an hour.

Mr. BECERRA. Six dollars an hour. About how many hours would you say?

Ms. GILLIAM. Forty.

Mr. BECERRA. Around 40 hours. So it's about $240 a week times 52.

Ms. GILLIAM. Yes. About $12,000 a year, that's right.

Mr. BECERRA. About $12,000.

Ms. GILLIAM. Yes.

Mr. BECERRA. Okay. So with 20 employees at $12,000, you would pay, under the President's plan, a total of $422.40 for all 20 employees for the year. Now, would $420 for the entire year cause you to go out of business? That's the entire year.

Ms. GILLIAM. Now, whenever you're talking about this type thing, you're not talking about only cost. You're talking about bookkeeping. You're talking about all these kinds of added things. You have to add employees who take care of——

Mr. BECERRA. Remember, now, under the plan that the President proposes, you'd just send over a check to the alliance and the alliance takes care of all the accounting, all the insurance. That's one of the streamlines in the system that the President is trying to do through these alliances. So you, in a sense, cut out the middle people, the insurance companies that require you to do all this paperwork. You just have to send in a check for the $422.

So that way, the alliance takes care of the insurance.

Ms. GILLIAM. Okay. That's one of the biggest concerns of the small business people. They are entrepreneurs. They are people who have seen a lot of things through the years, and you're talking about one giant bureaucracy. You're talking about one giant bureaucracy that's also going to be setting up bookwork for us, that's going to be setting up all this, as well as the collecting of the money that I would send in, and you're talking about keeping up with each one of these individual employees, and I'm talking about turnover. I mean, we have—consistently, we have about 20 employees, but we might run through 100 people, because we'll have people that will be there for two weeks.

Mr. BECERRA. Let's make sure about something. Whether you have 20 people employed in one month or 25, if your average is about 20, you're just going to send in a check for a total for the year for those——

Ms. GILLIAM. Who is going to keep up with what that $420 applies to?

Mr. BECERRA. The alliance would take care of that.

Ms. GILLIAM. But how many people is it going to take to keep up with those 100 employees?

Mr. BECERRA. And those are all valid concerns that we must address and that's why I can understand your skepticism about the numbers. But if all went correctly, as the President proposes—and, again, we don't know and we may not end up with a plan the way the President proposes.

But under the President's plan, you would be limited to no more than $422 in terms of your cost. Now, we ultimately may see a system that is so bureaucratically inefficient that they have to raise the caps or they have to include additional costs to the employer. But the way the President has it structured—and I'm not saying it's going to work or not work.

I'm just saying the way the President has it structured, these are the caps. Given the variables, your employees, your average wage,

the variables you've given, if we input that into the formula that the President has produced for the cost, it appears that you would have to pay about $422.40 for the year for the 20 or so employees.

See, that's why I say it seems that the President is onto something, if, in fact, he can follow through and make sure that bureaucracy doesn't overwhelm the system. I'm told by staff this is similar, in a sense, to the system that Social Security works under in providing the benefits to those who are senior citizens.

Now, I'm not asking you to adopt the system, agree to it. What I'm trying to do is put in perspective what's out there, because, see, too often we speak from disinformation or misinformation. If, in fact, it's true that your business could now provide a basic set of benefits to all the employees you have, whether they're full-time or part-time, for about $422, that, to me, would be a great deal. Now, whether it ultimately comes to pass, I don't know and that's why we have to delve into the President's plan in detail, because if, in fact, that's true, I think that would be a boom not only for you, because for $420 for the year, you get to do that, but also those 20 or so employees now get coverage that they didn't have before, and you could include yourself in the plan.

Ms. GILLIAM. But that is like a fantasy because there is no way that you could give hospitalization to 20 people for one year for $420.

Mr. BECERRA. That's correct.

Ms. GILLIAM. So who is going to pay for it?

Mr. BECERRA. That's exactly it. There is a subsidy here. You're not paying for the entire cost.

Ms. GILLIAM. But where is the subsidy coming from?

Mr. BECERRA. Obviously, it's coming from you and I as taxpayers.

Ms. GILLIAM. That's right.

Mr. BECERRA. But let me ask you something. You're already paying $5 for an aspirin tablet when you go to the doctor. Who's paying for that?

Ms. GILLIAM. I don't take aspirin. I cannot afford it.

Mr. BECERRA. Let me tell you. Excuse me just a second. Let me call to your attention we're in a congressional hearing. We're not in a football game. So you'll have the opportunity to testify and we can't have people expressing opinions on one side or the other. Everyone will have an opportunity.

I understand your skepticism. I'm not saying you should accept the plan. I am not even a cosponsor of the plan. I prefer to see a single-payer system in place than what the President is proposing. But what I'm saying is I would hope that those in small business would take a look at the plan in detail because I think you have every reason to be concerned about how it will be implemented, how much it will cost.

But as Mr. Schaper mentioned, the gentleman from the hospital mentioned, we are already paying, whether you want to call it a tax or uncompensated care, for the cost of providing medical care to people. The fact that you have a $5,000 deductible is due to the fact that health care is so expensive. You will have to put out of pocket $5,000 before you get any form of greater coverage by your insurance company

Ms. GILLIAM. Do you know what incentive that is? That is the incentive for me to stay healthy. That's the kind of incentive that we need for everybody to be thinking about, doing everything they can to stay healthy, not depending on anyone else. People need to get back to being responsible for themselves.

Just like she touched on the thing of going in and the first thing you know, they're running all these unnecessary tests and so forth. I hear this all the time from the people who go to the services that are now available. I have people going through tests that I couldn't possibly even consider, even if I thought I was that sick. I would just have to say I'll have to wait and see for a while.

Mr. BECERRA. There is no doubt if we allowed that to continue in any new system, whether it's the President's plan or single payer or Congressman Cooper's plan or the plan proposed by the Republican members of Congress, that we would always—we'd end up failing because we have to corral those costs. Absolutely.

But all I'm trying to do is get some numbers, because if you look at the plan—obviously, if this were a utopian world, an ideal world, that's the way it would work. You and I know that this isn't an ideal world. So there will be some kinks in the process.

But I'm just trying to get an idea of where you would fit in within the President's plan. I wish I had the variables and the formula for the other plans so we could see where you'd fit in those, as well. But you will have every right, given the way things have progressed with government and health care of the past many years, to have some skepticism, but I would hope that you would take a close look.

Let me move on now to Ms. Nerison. Before I ask you for the numbers in terms of the number of people employed and so forth, you mentioned in your testimony that your company right now is paying 20 percent above the national average for health care costs. Does that mean that you're providing a very solid extensive package of benefits or it's just costing you more to access doctors and hospitals?

Ms. NERISON. I think it's probably a combination of both. We provide a very good package, a package we're proud of, but we are also in Houston and Houston is a very high cost. Not only do we have the facilities here to provide outstanding medical care, but it does cost money. So it is a fairly high cost area and because all of our employees are located in that, that impacts our costs, also.

Mr. BECERRA. It sounded like you provide a very good package of benefits to the employees, and, you're right, Houston, like Los Angeles, is one of those areas that is high cost. Let me ask you. What is your percentage of payroll that you spend on health care at this point?

Ms. NERISON. It's, I'd say, right around 8 percent, 8 or 9 percent.

Mr. BECERRA. So under the President's plan, which puts a cap for any employer, larger employer, at 7.9 percent, your costs would end up being roughly the same.

Ms. NERISON. It might. I have to—I guess I would say that when big business and small business are agreeing on healthy skepticism as to whether or not costs are going to be controlled and whether or not administration is going to be streamlined, I would just have to tell you that I'm very skeptical about that.

Mr. BECERRA. And I can tell you that just——

Ms. NERISON. Because the problem here is providing—I think the reason, as I understand this subcommittee here, is to focus on providing access to care for those which don't have it, which appears to be one of the major problems. There is going to be a cost associated with that. While, as a large employer, we may see some benefit from that, as individuals, we're going to be picking up that cost, also. So it is not that that cost is going to go away.

Mr. BECERRA. Everything you've said is no different from what the current system is, which is that whether you as an employer pick up the cost, ultimately taxpayers pick up the cost of those who are either uninsured or underinsured.

Ms. NERISON. And we feel that, I think as I stated in my statements, you should focus on the policy issues and focus on those systems that are in place to provide care and assistance to some of those people that are in need.

Mr. BECERRA. And if the President's plan were implemented, more or less, the way he has described it, would the cap on any business of 7.9 percent of payroll for health care costs—in other words, no more than 7.9 percent could be spent by an employer for health care for employees—then it would fall within the range of what you currently pay now.

Ms. NERISON. Yes, it would.

Mr. BECERRA. So that if everything worked right under the new system, and, again, that's a big if, then your business, your company would not be adversely impacted by the Clinton health care reform plan.

Ms. NERISON. I would not agree with that. I think there are aspects of it that we would be adversely impacted by and I think it is reflecting on Ms. Gilliam's concern. We have a real concern that right now we offer a very attractive medical benefit and whether or not we would continue to be able to do that.

We have a great concern about the HIPCs and whether or not they would be efficient providers. I know they are supposed to—one of their functions is to purchase health care costs at affordable levels. I don't know if the Pentagon is going to train them on how to do this, but I think that is the reason for our skepticism.

So it's the hidden costs more than—it is perhaps the hidden costs more than anything else.

Mr. BECERRA. Your skepticism is healthy. There's no doubt about that. I suspect what we're going to find is up to the point where we have a vote on something, some plan, whatever it looks like, there will be a number of people who will be skeptical and the skepticism will probably drive us to something in the form of a compromise which will hopefully address concerns as best possible, although sometimes a compromise means it gets too washed down.

But I appreciate your testimony and, Ms. Gilliam, yours, as well, because those are the things that we have to grapple with, because we're trying to figure out how we take care of long-term care, how we take care of the 38 million uninsured, how we take care of the concerns of the business people, especially, in my mind, the small business people.

It's tough, because we get one vote and in that one vote we have to package everything that's going to be good for everyone. I've got to tell you it's very tough. But I thank you all for your words.

Mr. GREEN. Thank you. What I'd like to do now, and Ms. Richardson had to leave, but if someone would have questions or comments, of course, you can always call our congressional office, either the one on 420 West 19th Street or the 5502 Lawndale. But if you would like to give a short statement, you don't have to have anything prepared, just pick out the right mike so everybody can hear you and just, if you would, if you'd like to sit down and state your name and be as brief as you can, because I'd like to hear from as many people before we have to leave.

Why don't we just start with the gentleman right here and then the second one. We'll need your name very clearly for the record.

Mr. HENRY. My name is Frank Henry. I haven't heard anything about if you join one of these alliances, I understand you can go back at any time, but what—I have called—Blue Cross/Blue Shield is my coinsurance and I called them about this about this situation and they said if I do go and come back to them, I will have a preexisting condition for three months. This is not being advertised with that—you can join this alliance. You can go this way and you can go back any time you want to.

Mr. GREEN. What I understand is part of whatever plan, there are some things that are easy to be done and one of them is to eliminate the preexisting condition exclusions that some insurance companies put on you, no matter if it's Blue Cross or Aetna or anyone else.

But I don't doubt that that's what a given insurance company told you on that. Dr. Rosenau?

Ms. ROSENAU. That's one thing that the Clinton proposal, the Health Security Act, does consider.

Mr. GREEN. They can't hear you.

Ms. ROSENAU. That's one thing. You wouldn't have to make a choice at the present date, to the gentleman who just testified. You would belong to an alliance, if the bill were adopted, the Health Security Act, and, at that point, preexisting conditions would no longer be permitted as criteria for allowing you to change from one plan or another. Alliances are sort of like consumer protection agencies and purchasing pools.

They are by geographical area or corporate alliances are for those who work for a company with more than 5,000 employees. On the other hand, plans are the things we get to choose and those are packages of benefits. But most of the health care reform bills, including Clinton's, have all of the benefits lined up that have to be provided by every single plan.

The plans will put together providers, doctors and nurses and different kinds of care facilities, and then state a price per customer. Then the alliances will negotiate. So when we come to choose, as citizens and consumers, our geographical alliance of greater Houston would give us a list of how much it would cost per year and we would choose whether we wanted it to be fee for service or HMO or PPO or any other kind of plan. But we would have a choice of which program we wanted.

That goes back to the question the gentleman had at the very beginning of would I—you had, Congressman Green, about would we have to go to the hospital or could we go to the hospital nearest us. That would be dependent on whether the plan we chose had a contract with that hospital. If that was important to us, we should look for a plan offered by our alliance that has that hospital as part of its serving provider system.

Mr. BECERRA. But the simple answer to Mr. Henry's question is that, no, he could not be denied coverage because of a preexisting condition for three months.

Ms. ROSENAU. I would say that would be true after health care reform is adopted by Congress, but I would certainly not advise him to make any changes at the moment.

Mr. BECERRA. Right. Stay where you are.

Mr. GREEN. The gentleman in purple, just state your name for the record.

Mr. MOZZERELLA. Good afternoon, gentlemen, ladies, members of the public. My name is Roberto Mozzerella. Can you all hear me? No. My name is Roberto Mozzerella. I'm President of the National Health Federation here in the Houston Chapter. Can you hear me?

Mr. GREEN. We can.

Mr. MOZZERELLA. The government has demonstrated a steady incompetence in every area it has taken over or regulated. We don't see that that's about to change right now. I want to read a short little statement here into the record. In 1906, when the Food and Drug Control Act was passed, the government took over the control of making and selling food and drugs. How effective is the FDA? Before the law was passed, one could obtain any food or drug necessary. Drug addiction was rare, less than one percent.I22Drug prices were extremely low, no $5 for an aspirin, $10 for a Tylenol. No one was imprisoned for drug related crimes. People took responsibility for their health. After the law was passed, a drug black market was created. Drug prices rose ten-fold. Food went up, too.

Imprisonment for drug-related crimes began. People became irresponsible about their own health, believing the lie that doctor knows best. Now, illegal drugs are our single largest industry. Legal drugs are one of our largest industries.

Our prisons are bursting with people who tried to make money from drugs. More and more totally safe and healthy herbs, vitamins and food supplements are made illegal and unobtainable every year. More than 100 million people are walking around with deadly mercury in their mouths. One-third of our populous is expected to get cancer.

America was one of the healthiest nations in the world. It is now one of the sickest. Americans spent $800 billion disease care last year. Perhaps we need to rename this information and say not health care, but disease care. Health has to do with wholeness. The present medical system is wholly dedicated to sickness and disease.

We need healthy, whole foods, not diseased and rotting meat, as we saw on the program 48 Hours a week ago, and deadly pesticide-laden and irradiated fruits and vegetables. Hypocrites said let thy food be they medicine and thy medicine be thy food.

When we put the kinds of food into our bodies that are being fed to the American public now, what else can we expect but rising sickness and more medical costs?

We need to focus our attention on wholeness and health and not on sickness and disease. I thank you. God bless everyone.

Mr. GREEN. Thank you, Mr. Mozzerella. Mr. Ortiz? We have a lot of people who would like to testify, if you could be as brief as possible. If you'd like to submit written statements, feel free to address them to us. Like I said, we'll submit them for the record to either of our district offices and the staff members, Kathy or Ron or Moses in the back, can give you the address. Mr. Ortiz?

Mr. ORTIZ. Congressman Gene Green and Congressman Becerra, I will answer your question on who is going to pay for what. I want to say thank you very much for taking the initiative to hold this hearing on health care.

But I understand that over 800 issues will be debated come mid-April. I'd pose to you the following, which are just a few of the thousands of cries in the valleys, the barrios and in the wards.

As a concerned citizen and voter and a member of labor and a former United States Marine, I am looking forward to a universal coverage and securities act that is an aggressive health care that applies to every American, and those in the Marine Corps, and others in the American Armed Forces, and those Americans, taking into account those thousands of those persons who have built our homes, building towers, and plowed our fields, but are not yet of American status.

Regardless of the employment, economic status and, of course, taking a preexisting condition, remember, we the Nation need and adhere to a cost containment and quality of medical care across the board, and that's including the doctors and a fair financing.

Congressmen, a true bite, and, believe me, a true bite and a big picture of a true sound writing of long-term health care. I come to you as a member of an Alzheimer's disease victim and a parent of a healthy family to plea with you that these people and others afflicted by chronic illness or disabilities, they and the caregivers have the right to a complete health care. The illness will probably—this illness will probably be a financial disaster to the rest of the family.

Once again, I ask you to take a strong look at long-term health care, only because—and it is estimated by the 21st century, 14 million Americans will have this disease. You will bring these and other issues to a vote or a floor action by mid-April. I and on behalf of others, I ask you and the Committee Chair, Representative Bill Ford, to hear us out and, please, no more band-aid applications.

We all need real health care and a true comprehensive and quality care for all at a fair and affordable cost. I encourage you to seek out a strong battle cry for fixed benefits, as there are none and there will be no guaranteed basic package, and the coverage could be watered down.

Do continue to enforce and keep intact preventative care and services to our children. Let us not forget that our employer has and should be accountable for our contribution to his existence by continuing to pay 80 percent of the cost of the standard health insurance for their employees. Keep intact the employer mandate.

In conclusion, I believe that a total and complete care for the men and women in the Unites States Armed Force, retired, active, ready reserves and their families, long-term health care for Alzheimer's disease and those afflicted by chronic illnesses and disabilities, those persons, documented and not documented as of yet, employer mandate, prevention care and services to our children.

Avoid the band-aid application and I promise I will support the Health Security Act, providing that universal coverage and that cannot be taken away from us; cost containment, quality care and a fair financing will not be denied to any of the American population and those that choose to be here.

Congressmen, I stand ready to assist you and your Committee on the efforts of this one national benefit. And, Congressman Becerra, I pose to you that a reduction of 15 percent of foreign aid be the next piece of meat on your plate. Many countries have been refusing and have refused to pay up their ante or pay up their debt for the financial aid that the United States has paid them or given them to rebuild these foreign countries.

Surely, right after World War I and World War II, Korea, the Pacific Campaign, none of these foreign countries has yet paid the debt they owe us. I assure you we will be paying foreign aid to the Vietnam people.

Congressman Becerra, and I have not yet seen a foreign country come to the aid of the Californians. Thank you very much.

Mr. GREEN. Thank you, Mr. Ortiz.

Mr. BECERRA. If I could just, to Mr. Ortiz, respond. I think his last point is very well taken. One of the things that we found in the last bill that we had on foreign aid was a number of us were trying to get a better commitment from countries like Japan and some of the European countries that have a lot of our U.S. forces there for them to reimburse us for the services that we're providing.

Unfortunately, we were not successful. But a point just so it's clear how big and horrendous this whole health care crisis is. If we were to take 15 percent off of foreign aid, we would have approximately $3 billion, because foreign aid amounts to about $21 billion total. So about 15 percent would be about three billion. Three billion, in a gaping hole of over $800 billion, is nothing, and that's why we need to do more than just take the 15 percent.

We'll have to do more, and that's restructure the way we do health care overall. But thank you very much. Your comment is well taken.

Mr. GREEN. Yes, ma'am. Make sure we have your name and, again, be as brief as possible, because we have a lot of folks and Congressman Becerra has got to leave at a little after four.

Ms. SHELBY. My name is Tamara Shelby. My husband I own a small business and I share with Ms. Gilliam her concerns. A lot of our workers are very transient. It would be a nightmare to keep up. But this is from myself personally. I do not feel that the Federal Government has any business getting involved in providing health care.

I'm afraid it's going to be just as ineffective as Medicaid and Medicare. When it was conceived, the cost was X amount of dollars.

Now it's many more times that and, yet, it's still not taking care of the problem.

Also, Social Security, the same thing. Any time the Federal Government gets into a program, we have high costs and low effective rates. I, as an American citizen, would like to have the right to choose and I personally want the Federal Government to stay out of my pocket. They've dug deep enough.

I would like to ask if there's a provision in the Clinton plan or any other plan that would allow for those of us who are absolutely opposed to participating in what I feel is a folly, and that's about as kind a word as I can use, or is this going to be shoved down our throats like so many other things that the Federal Government feels is "in our best interest?"

Mr. GREEN. I don't recall any exceptions. The Federal Government, State government, city government. We get everything shoved down our throat when some legislative body or executive body, whether it be county commissioners, tell us we have to pay a toll or the city tells us we have to lean up our yard.

So I guess you could say there's a lot of things being shoved down our throat. I don't know if there's an exception or a safety valve for someone who doesn't want to do it are more than there is for minimum wage, except there are some exceptions. So I guess we could see some exceptions to it. But, again, that isn't part of any of the plans that I see.

Ms. SHELBY. I just feel that the American people should be more responsible for themselves and we also should have that choice, because I don't believe the founding fathers really thought of health care. They thought of the basics for the Federal Government to take care of and if the Federal Government could take care of the basic things, like defense, foreign policy, and do that well and let the rest of us take on more responsibility as a citizen, things would work out a lot better.

Thank you.

Mr. BECERRA. If I could just say, Mr. Chairman, I think you probably hit it right on the money when you say that we as individuals should be taking more responsibility. The problem is what we found, and that's why we have this crisis, is that Americans have not taken on, individually, that responsibility and the problem is it's costing each one of us as taxpayers.

The reason you pay so much in taxes is because there's so many individuals in this country who have not taken on their share of personal responsibility. I wish we could go your route, but what we're finding is that we don't have enough individuals who are willing to be as responsible as you.

Mr. GREEN. Thank you, Ms. Shelby. Mr. Salazar?

Mr. SALAZAR. Congressmen, I'm George A. Salazar. I'm a retired Teamster. I'd like to bring to your attention that the Teamsters—the unions have been in between people like myself, the ignorant, the simple people and large families who have solved a lot for us here in this country and not to forget them. Thank you.

Mr. GREEN. Thank you, Mr. Salazar. Dr. Nichols?

Dr. NICHOLS. I'm Dr. John Nichols. I am in family practice. I want to commend the congressmen for a very enlightening afternoon. I think your witnesses have been great. It occurs to me that

it is a system that can work. We're already partly socialized with Medicare and Medicaid and I take care of both families in my practice. The fact is I've subsidized my practice because of inadequate payments. I have a son who is a radiologist, who doesn't need subsidizing his practice.

There's a real gap between what he makes and what I, in family practice, make. I'm not concerned about that. I am concerned that we have medical coverage for everyone. I think it's a great idea. I think the managed care, the regional alliances can work if properly administered.

I would be totally in favor of establishing a system where everybody, all 260-some million people in this country, could have care. I think that maybe what you said, Congressman Becerra, that maybe the Clinton plan is onto something, because here we have an individual who has 20 employees and could have coverage for her 20 employees.

We have, as Congressman Green mentioned, the florist who says I have to add 20 percent because I can't cover it. I think it's worthwhile to consider and I commend you for having this meeting and certainly for the illumination to me of what managed care could mean.

Thank you.

Mr. GREEN. Thank you, Dr. Nichols. Yes, sir?

Mr. WILLIAMS. I'd like to say you're saving the best for last, but thank you very much.

Mr. GREEN. Well, I don't know if you're last.

Mr. WILLIAMS. John Paul Williams is my name. My statement has to do with health care choices. The present health care system is actually a sickness care system. This system presently in place does not support true health care practices which address the causes of disease.

I request that Congress allow Americans to practice alternative health care methods without interference from David Kessler and the FDA. True health care is brought about by individuals becoming knowledgeable through proper nutritional education and the daily practice of ingesting clean food, air and water, along with high quality supplementation of vitamins, minerals, herbs and amino acids.

Our society must address the most basic needs of the human body. The human body will be healthy, for the most part, if it is taken care of properly. We do not educate our children about the consequences of a bad diet. We can reduce the cost of health care by increasing the awareness of our society to what health care really is.

It is stopping the causes of disease which are directly related to our food, air and water, thus resulting in good health. While we taxpayers subsidize tobacco, dairy and cattle farmers, we allow the FDA to harass those in the alternative health care industry in order to control our access to low cost products and services. Dr. Guerrero spoke on diabetics being out of control. I submit that our society as a whole is going out of control because we are an unhealthy society.

We need to have the freedom to supplement our diets. This statement has to do with health care, not sickness care. Please protect

our right to have access to the only means to truly avoid disease. Drugs do not and never have cured any disease.

Last, I would just like to say that a great writer, Thomas Edison, said the physician of the future will prescribe no medicine, but will instruct the patient and the care of the human frame proper diet and in the cause and prevention of disease.

Thank you very much.

Mr. GREEN. Thank you, Mr. Williams. Anyone else? The lady in front of you, Perry, and then Perry. If that's okay, we'll have one more witness after this lady. Again, you're welcome to have your statements—either you can write it or give us a call at one of the district offices.

Ms. WINKLER. I appreciate this opportunity to hear all this.

Mr. GREEN. Give us your name.

Ms. WINKLER. Elizabeth Winkler. I appreciate this afternoon of information and I feel like I've learned some things and I feel like I still need to learn a lot more and I have a lot of questions, but I'll only ask one.

May I ask one brief question rather than make a statement?

Mr. GREEN. We'll try and answer it.

Ms. WINKLER. I believe it was the lady who was the first speaker, I wrote some notes down as the speakers spoke, she said everybody in the country will be assigned to an alliance. Now, I'm just going to ask about this statement. I don't know how bit a geographical area an alliance is going to cover, but if it doesn't cover, say, an entire city, I visualize a person who may have a doctor across town that is not near them and they want to go to that doctor and that doctor's hospital, but if they're divided into geographical areas, this alliance isn't big enough to encompass the entire city or county, they may be—if they're assigned to an alliance, they may not get to choose the doctor they want.

Is that going to be the way this is going to be?

Mr. GREEN. I think she answered it that the alliance, for example, for Houston would be all of Harris County.

Ms. WINKLER. I guess I didn't hear that part.

Mr. GREEN. I share that concern, too, because I don't want—we have a lot of people from, say, north Houston who go to Parkway, but people don't necessarily want to have to go to Parkway. They want to be able to go to the medical center or anywhere else.

The alliance would be the total geographic area in the scheme. The actual package that you buy or you choose could either be—could have Parkway and Methodist or could have Parkway and Herman or any number of physicians, and be similar to what I've seen under current plans or PPOs, preferred providers.

If you have an employer-based plan, they give you—you have this plan that says, okay, you have 50 doctors you can choose from or a 100 doctors and then you have this many hospitals. Now, you can go to any hospital on an emergency basis, but if you want to have your plan to cover it, then these are the ones you choose and if it's your doctor or the hospital you go to, like I was born in St. Joseph's and the only time I've ever had anything is at St. Joseph's, and I would obviously like to have St. Joseph's on mine that I would do. Of course, my wife might want somewhere else.

But it would be geographic and not necessarily—I mean, county-wide and not necessarily small geographic, like in one particular segment of town.

Ms. WINKLER. But if you're in, say, this Harris County alliance and there's different plans, among the different plans, suppose the plan you would like to be in has a group of doctors or one you want to go to then. Is there the possibility that before they get to your name, say, like if it's the end of the alphabet, like mine, W, they filled up that plan and they say we're sorry, but you'll have to choose a different plan because those people have already been filled up with all the patients they can take.

Mr. GREEN. Well, I don't know if that's how the system is going to work.

Ms. WINKLER. I'm just asking.

Mr. GREEN. If they're just going to do it alphabetically, because I know people who have told me that doctors now tell them they don't have any more room for patients, particularly some specialists.

Ms. WINKLER. But if you—the ways things are, you're going to a doctor and you have a doctor, but you have this big alliance that says, okay, I don't—I'm not going to say it's alphabetical. Disregard that. But whatever system they have of dividing you, if they say, well, by the time we got to your farm, we had already filled up the plan your doctor is in and we're sorry, but you're going to have to go to Dr. XYZ and you don't know anything about Dr. XYZ or whether you even want to go to Dr. XYZ.

Mr. GREEN. I would think those plans would want to have big expansive plans to serve and, frankly, the more people they serve, the more money they make, and that leaves the profit motive in the health plans that we have.

The staff might have and Congressman Becerra may have more information.

Mr. BECERRA. If I could try to just real quickly answer a couple of them you asked. First, remember, the State will decide how many alliances there are and how big they will be. But as staff mentioned to me, none will be smaller than a metropolitan area. So it should address the concern you have of an alliance being too small.

But those are ultimately left to the State to decide. So you don't have the Federal bureaucracy making decisions for you locally.

In terms of whether a plan will reach capacity, remember, now, try to distinguish between the alliance and the plans. The alliance encompasses a large geographical area and is like a clearinghouse. It will offer any number of plans. Within those number of plans, the doctor you wish to go to or the provider or hospital you wish to go to may be under more than one plan, in which case you have a number of options. It will be a menu.

So the chances of your not being able to get into the plan with the doctor you desire are small, but that's a very good point, because if everyone knows about a great hospital, everyone may say, well, I want to go to that hospital. I suspect what will happen is locally the alliance will try to deal with that, but the short answer is it is unlikely that you will not have a chance to get into the facility or to the provider you wish.

But that's why it's so important for you to come to these types of hearings, so you can make sure that once a plan is implemented, whether it's the President's plan or anyone else's, you have input on how it actually is implemented, because that is, I think, the biggest concern people have is how will it be implemented.

The small business people are afraid it will cost them too much. Individuals think it won't be any better than what they have. It will cost them too much.

I hope you all continue to stay informed and continue to attend these types of hearings, because, quite honestly, the people who will vote and make the policy and what the plans look like don't know what they're going to look like either. We will be influenced by what you all have to say.

Ms. WINKLER. I think this is a gigantic undertaking and you have my sympathy, but I think it's very complex and it's not going to be perfect, I'm sure, no matter what is decided. But I have genuine concerns about these alliances. I have a view of a giant bureaucracy that's going to break down and take undue amounts of time to process a lot of stuff.

Mr. BECERRA. You have a very receptive Member of Congress right here who probably represents you, if you live in his district. I guarantee you Congressman Green, like Congressman Becerra, like any other member of Congress, whether it's Congressman Foley, the Speaker of the House, if you—and you can include the President of the United States, no one knows what the final content of any plan will be and I guarantee you you have as much ability to influence what's in the plan as anyone else.

It's just a matter of how active you are to make sure you address the concerns that you have and the questions.

Ms. WINKLER. I'm very happy with my congressman and hope he gets reelected, but the Congress, as a whole, I have a lot of misgivings about. I read things everyday. I read about this——

Mr. BECERRA. He's good at approaching a lot of different members.

Ms. WINKLER. Some military base was in the Houston Post yesterday that, I forgot, a few million dollars, which is pennies to you congressmen, but a few million dollars, like $11 or so, or maybe it was $100, I don't recall, but is being—has been allotted to upgrade that facility which is due to close.

Now, us ordinary folks, we do not understand the logic of that and when we read that and we read a lot of other things that we are told about every day or frequently on Prime Time Live or 60 Minutes or in the Houston Post or Houston Chronicle, we think and these people are going to make our health care system better.

We understand the problem about preexisting conditions and non-supportability and all that, but it scares us to death when we see the things that are being done up there that make no sense to us ordinary folks. Like why upgrade a military facility that's going to be closed? With the kind of reasoning that is going on up there, we wonder if some people up there are drinking toad juice, like we read about in California. You have a problem out there.

Mr. GREEN. Well, I don't know about that. But the decisions on whether to upgrade military bases or not—and in our district, we

only have a Coast Guard facility and they can't do much to it, but——

Ms. WINKLER. But it's our tax money if it's in another State, too.

Mr. GREEN. Yes. And it is. But, again, the Federal Government is so big, I didn't know about that until I read about it in the paper yesterday, too. I'm not on the committee that deals with armed services, but we also get our information sometimes from the front pages of the local newspapers.

Ms. WINKLER. I understand you have so many problems and there's so much up there to deal with, no one human being can be on top of everything. But that in itself is the reason why we're worried about the health care system putting all this onto the government on top of what you already have to deal with. It is impossible for one human mind to keep on top of.

Mr. BECERRA. Ms. Winkler, before you leave, if you don't mind my commenting. I would so much appreciate it if everyone who came and spoke to us as members of Congress addressed us the way you did, because you didn't say that we're guilty of causing you all these high taxes. You addressed us as individuals. We're no more than—we're no different from you. We're ordinary individuals who happen to have gotten elected.

I've got to tell you, because I often, in my district, get hit by people who will take a very irrational approach, everything you've said is absolutely on point, absolutely on point. I would hope that more individuals would take the tact that you've taken in addressing these issues, because if people did that, then I think a lot more members in Congress wouldn't feel like they don't have to pay attention to their constituents. They would be more like Gene Green and they would pay closer attention, because you addressed us in a very rational way.

There are problems and there is reason to be skeptical and the reasons that were pointed out by the folks that are in business. But, unfortunately, sometimes people communicate it in the most negative of ways and it makes it very difficult to get anything done.

So I just wanted to thank you for——

Ms. WINKLER. Well, I do think we have a good congressman in this district and he holds town meetings and we throw all kinds of questions at him and he always comes back with an informed answer. He knows what people are asking and he has a sensible answer. I understand people don't like Congress and I get frustrated, too, and I understand there is just so much going on up there, no one human being can keep up with everything going on.

I can understand the reason why. There's just information overload. There's so many hours in the day and you're trying to meet with your constituents and inform them and listen to their concerns and, yet, be informed on every topic under the sun and weed out all the waste and corruption.

But that's why I worry about health care, the health care problem. How is the government going to take on all this additional and make it more efficient and work, and we don't have to wait nine months to get an appointment with our doctor.

Mr. GREEN. Believe me, we relate. Mr. Hicky?

Mr. HICKY. Thank you, Congressman. I'm Perry Hicky. Up until about a year-and-a-half ago, I was the owner of a couple of small businesses. I sold them to my employees. They're buying me out, so to speak. Prior to that, three years ago, I had a couple operations and the bill on one was something like $17,000 or $18,000. The insurance that we had with the company at that particular time, a group insurance policy, came up after the operation and informed me that it was a preexisting condition.

So it left me holding the bag of about $17-$18,000. So what did I do? Number one, I hired a lawyer. Number two, we sued them. Number three, I went to the doctor to see what kind of payment schedule could be worked out and the doctor says, well, if you've got cash, I'll settle for half my bill. I said that will be fine, I can arrange that.

I went to the hospital and they said, well, we won't settle for 50 percent on the dollar, but we will for—we'll give you a 25 percent discount for cash. So I went out and borrowed the money and paid them off.

The thing is the insurance companies know that doctors and the hospitals evidently have two bills and they're going to get as much as they can, and that is the reason that the hospital—that the premiums, the health costs is going up, because they know that they're going to get stuck and presented with a high bill.

If the insurance company will continue to pay it, then fine and dandy. My contention is that with this new Clinton plan, with the—even though I'm not in the business directly, I'm still in it indirectly, but we've got a hospital plan with our employees at the present time. We're paying 50 percent. It's a struggle to pay 50 percent of the premiums, because the premiums are $1,400 a month.

If we are going to be required to pick up another 30 percent, that's another $5,000 a year that we're just struggling with that right now and I don't know for sure whether or not that bureaucracy that is going to be put in place with this new plan, what kind of additional taxes are going to be hit as far as the business is—a small business is concerned.

I know that we are continuously being hit with the hospital district and we're paying for indigent care and we're doing—we're picking up—the taxpayers are picking up the charges anyway for the people that do not have any kind of hospitalization. So the big worry that I have is whether or not these employees that have bought me out, so to speak, whether they're going to be able to continue to pay me or stay in business and whether or not I'm going to have to take it back over.

I'm up in the air on exactly what it's going to cost. Now, I, myself, I'm not worried about my situation, but the business, even though I'm not directly concerned with it at this particular time, I'm still indirectly concerned.

Mr. GREEN. For the benefit of the committee, Perry and I have lived in the same neighborhood for longer than we want to realize and I know the business you're involved in. The biggest thing, I guess, the summary that I hear from my own constituents is that the lack of knowledge or how it's going to ultimately work.

This committee hearing was to talk about all the various plans and hear testimony on the problems that we have with the current

system, particularly people who can't afford it, because we don't have—I wish I could tell you that the employees who bought the business will next year be able to do it. Of course, if they get the President's plan, according to the informal numbers that were put together, I think you would see a great deal of reduction from $1,400 a month. How many employees do you have, Perry?

Mr. HICKY. Eight.

Mr. GREEN. And the average income is probably, what, $30,000?

Mr. HICKY. Something like that.

Mr. GREEN. I would think you would see a substantial decrease. And, again, that's the numbers we've seen that are all preliminary. Until our committee and the two other committees start putting it together, we don't know what the impact will be.

But I think all of us recognize there's a problem with health care in the United States, because the costs you're paying and the costs I was paying before I was elected to Congress and in our business was just outrageous. We were seeing 20 percent increases every year.

We went to a PPO because we couldn't afford 30 percent. And we still had the frustration with the PPO, we were still seeing—and we had 13 employees. I guess the average income was about $30,000 a year for a printer and for the whole business.

It's frustrating. We're putting together a plan now to guard against pricing people out of the market, because if nobody can afford it, we won't have a plan.

Mr. HICKY. With the present system that we have, of course, everyone knows that it needs to be changed. There's no two ways about that. If we could get control over the hospitals at $5 an aspirin, I believe, that's the reason that they could adjust your bill down, because they've got it built into the costs to begin with.

Mr. BECERRA. Mr. Perry, that is exactly the way we're going to try to keep some of the costs down. So that whether it's an individual or a small business, I can understand the skepticism. If we can't corral those costs, we won't be able to do it and we'd be fooling anyone to say that the individual or the business will not pay more.

So that's probably the real linchpin. We have to be able to control the costs. If we don't ever do that, if we can't get some sanity into the cost of a real aspirin tablet, then we're in trouble.

Let me make sure about something, Mr. Hicky. You said $1,400 per month right now and that's 50 percent coverage.

Mr. HICKY. That's the employee pays 50 percent.

Mr. BECERRA. Right. So you are covering half of the health care benefit package right now and your employees average about what wage per year?

Mr. HICKY. Probably $30,000.

Mr. BECERRA. Okay, about $30,000. Again, this is under the President's plan, in isolation, we're looking at it, if it could be implemented ideally, with less than 25 employees at about $30,000 in average wages, you would be paying the 7.9 percent cap on total costs from your payroll, which would be no more than $1,580 for the entire year.

Mr. HICKY. That's the employees' share?

Mr. BECERRA. That's your share and that's 80 percent. Eighty percent for the entire year. So what you pay right now for one month, and that's 50 percent of the cost, you wouldn't be paying——

Mr. HICKY. Well, the $1,400, 50 percent would be actually $700.

Mr. BECERRA. I'm sorry. So $1,400 is the total. So you're paying percent, so that's $700. So in a year, 12 times seven, that's—so you're paying about $8,400 per year for your less than 20 employees. Under the President's plan, if the numbers you've given me are accurate and the numbers in the President's plan were to be accurate, again, the ifs, you would pay not $8,400 for the year or the employees who are buying the business, but they would be paying $1,580 for the year, so a substantial savings.

Now, again, that all is contingent upon us being able to corral costs and do a number of different things, but the whole thing on health care reform is really pegged. It's predicated on us being able to really bring some sanity into the system. We don't need to have all these insurance companies pushing paper across our desks for the employers or the doctors. We don't need to have $5 aspirin tablets. We don't need to have specialists who do dermatology numbering more than our preventative family care physicians.

So all those things have to be placed in line. So there are a lot of ifs. But if the President's plan could be rigorously adopted, the employees who are buying your business might find that they're going to actually do better.

But that, of course, requires all the folks who are very skeptical to continue to raise the skepticism so we can make sure we end up with a proper system.

Mr. HICKY. You don't believe that there'd be any additional burdens put on the bookkeeping and so forth on the businesses.

Mr. BECERRA. That's supposed to be taken care of by the alliance. By having the alliance, you no longer have to have the employer dealing with an insurance company. That's one of the biggest problems. Some people estimate that the costs of just paper pushing, the administrative costs of health care insurance are about $80 billion. That's the insurance companies requiring you to fill out all this paperwork, doctors being required to fill out all this paperwork.

That would now no longer be required of a doctor or the employer or the employee, because it would be done through the health alliance. The whole concept behind the health alliance is we're giving the recipients of the care, the consumers of the care, leverage, which they don't right now have.

You don't have a lot of leverage as a small businessman, but if you are part of one huge alliance with maybe 1.2 million people, then all of a sudden those health providers want to give you a competitive rate and you're sort of bypassing the insurance companies.

Again, I hope you all will continue to push, especially those of you in small business, because you can't hope that it will happen, you have to make sure you work to make it happen.

Mr. GREEN. I want to thank all our witnesses, both the panels, but also the people who testified, and thank Houston Community College for providing us the facility. Again, for some of us who have come to Northline all our lives to see this rebuilt facility.

I'd like to thank Congressman Becerra for stopping by on the way back to Washington for tomorrow. If he doesn't leave pretty quick, he's not going to make that 5:30 flight, even out of Inter-Continental.

But thank you, again, and our office address is 420 West 19th Street, 77008, if you'd like to provide some written statements.

[Whereupon, at 4:25 p.m., the subcommittee was recessed, to reconvene at the call of the Chair.]

H.R. 3600—"THE HEALTH SECURITY ACT: CHILDREN'S MENTAL HEALTH ISSUES"

TUESDAY, FEBRUARY 22, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m., Room 2175, Rayburn House Office Building, Hon. George Miller, presiding.

Members present: Representatives Miller, Woolsey, Strickland, Roukema, Gunderson, and Hoekstra.

Staff present: Phyllis Borzi, counsel for Employee Benefits; Gail Brown-Hubb, staff assistant; and Allison Hogue, staff assistant.

Mr. MILLER. The Subcommittee on Labor-Management Relations will come to order.

This is a continuation in a series of hearings that this committee has had dealing with various proposals for health care reform; and specifically today to focus on the issues of mental health and how they will or will not be covered, what should or should not be done.

We will hear from a group of witnesses who are experts in the field in a number of different areas of providing mental health services, and specifically in many instances dealing with the issue of mental health services as they relate to children.

We think it is important that this subject be highlighted as part of this debate, and that we continue to press forward to make sure that mental illness is treated as any other illness, that it is not treated differently in the various health care proposals, or that we start to deal with it on a nondiscriminatory basis. We also must deal with it so that the treatment of mental illness can be medically indicated as well as insurance indicated or some other indication, and that we start to deal with it as any other physical illness.

It is a topic we are not completely comfortable with as a Nation, but clearly it is an issue that affects millions of Americans and their families, and we must seize this opportunity as we grapple with the overall issue of health care reform to make sure that we give the attention to the issues surrounding coverage for mental illness that is due.

I want to welcome Marge Roukema, who has spent an awful lot of time working in this area, to the hearing this morning.

Is there any statement you have?

[The prepared statement of Mr. Miller follows:]

STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

I would like to welcome you to this hearing before the Labor-Management subcommittee on Children's Mental Health Services under health care reform. We singled out this issue for a hearing because children with mental illnesses—some 12 million nationwide—have unique service needs that must be adequately addressed in any health care reform proposal. Systems serving children that are the jurisdiction of this committee—the Juvenile Justice System, the educational system—deal daily with children with mental disorders and the inadequacies of their treatment.

We are not comfortable with mental illness, particularly as it effects children, and often have tried to ignore its existence. We all know children who are unusually aggressive or withdrawn, who act out in school, who get into trouble with the law. These are often not symptoms of the phases of childhood, but manifestations of serious mental health problems. If left untreated they will persist, magnify, and have serious implications for the individuals' life and the nation in which they live.

And, untreated they often are. Children's mental health services are a national disgrace. As many as 80 percent of children with mental disorders get unsuitable services or no services at all. Psychiatric hospitalization, often the only alternative for more serious cases and always expensive, has been escalating.

The objectives of this hearing are twofold. First, as each witness will undoubtedly point out, mental illness is just that—an illness—and should be treated as such in health care legislation. We cannot, in the name of cost containment or just plan ignorance sweep it under the rug with a campaign of silence. Discrimination against the mentally ill in any health care reform benefit package cannot be tolerated any more than discrimination against persons with one type of a physical disease. Failure to provide such coverage does a disservice to the sick—whether they be children or adults—and to our Nation which will pay much greater costs in the long run.

The other objective of this hearing is to examine the most effective treatment alternatives for children who suffer from mental illness. After many years of examining the problems of children and their families and public systems that serve them, I have concluded that community-based, family intervention services furnished through interagency systems of care offer the most promising broad-based approach for treating mentally ill children. I am particularly interested in what our witnesses think of this approach. Model programs exist. We are fortunate to have several witnesses who have had first-hand experience with such models and can speak to their effectiveness, including Randall Feltman, who is Director of the Ventura County, California Mental Health Department.

I am proud that the 102d Congress enacted my legislation, the Child Mental Health Services program, under the Department of Health and Human Services' Center for Mental Health. This program, currently funded at $35 million, offers grants to States and communities to stimulate the development of community-based services to be available, as needed, to mentally ill children and their families. The philosophy behind the program is that the child is the center of services that are "wrapped around" his or her needs; also support is provided for families so that the child is cared for at home.

Our witnesses will provide a broad perspective on the nature of children's mental illness and the most appropriate and effective types of treatment. They represent not only the mental health treatment community and the multiple service delivery systems that are affected by mentally ill children, but they represent experience.

Our lead witness is a mother with her three sons, who can each tell the poignant story of how serious mental disorders can shape lives: how the private and public systems can fail and succeed. Ms. Davidson, Andy, Ephraim, and John—I particularly appreciate your willingness to testify.

Mrs. ROUKEMA. Thank you, Mr. Chairman. I certainly appreciate your convening the hearing this morning, although with many of our colleagues probably on airplanes trying to return. I don't think their absence is an indication of lack of interest in the subject.

And I want to commend you for initiating and organizing today's hearing. Certainly no one can question the merit, at least I don't believe anyone could question the merits of examining the problems in our present health care system with regard to mental health services as a total entity, and particularly those of children as we are focusing on them today.

As members of the subcommittee know, and I am sure you know, Mr. Chairman, but I don't know if our witnesses know, my husband has been a practicing psychiatrist for many years and has done a lot of work with children as well as adults. I think that says a lot in terms of my own commitment to it.

And I would state that—my husband, having done his psychiatric residency work at the locale of the snake pit, if you remember it, Rockland State Hospital in New York—it is a shame, I am afraid that all too many people in this country still have a snake-pit mentality with respect to mental illness and its treatment. Today the scientists in our mental health system have given you breakthroughs in all areas, and very appropriately in health care as well.

In my opinion, too much has been made of the cost-effectiveness or the cost-benefit-analysis part of our health care examination of the health care bill. But if we are going to apply that, we better apply it to mental health and understand there is a cost-benefit analysis. I hope our witnesses today will stress the fact that investment in mental health has great beneficial cost savings at the other end.

But I also might say that for all these reasons, they are the reasons that I have joined our colleague, Senator Pete Domenici in the other body, and have introduced the Equitable Health Care for Severe Mental Illness Act, which calls for parity and equal treatment for mental health care in any health care reform proposal that we enact. Our bill reasserts that mental illness is not a character flaw or personality demon, but is a real medical problem in as much need of treatment as a broken leg. The failure to address mental illness as a real and medical problem is costing society and American taxpayers billions of dollars every year.

Mr. Chairman, I won't go on for too long. But I must say in the other hat that I wear, aside from being ranking on this subcommittee, I am the Ranking Member of the Housing Subcommittee, that as an original cosponsor of the homeless bill, the McKinney homeless bill, that it has been all too long in coming that we recognize that a good deal of the homeless problem we continue to grapple with really stems from the problems of mental illness, and the ill-conceived—not ill-conceived, but ill-administered deinstitutionalization programs of the 1960s and 1970s. This understanding of homelessness has to be understood in the context of complete community mental health services.

So, Mr. Chairman, I really appreciate this opportunity here today. I am looking forward to the witnesses. They are well selected and well informed, and let's get on with the hearing

Mr. MILLER. Thank you.

Our first witness today will be Ms. Lynne Davidson from Richmond, Virginia, accompanied by her three sons, Ephraim, Andre, and John.

Would you like to come forward, Ms. Davidson. Welcome to the committee. We want to thank you very much for taking your time to come here today.

I have had an opportunity to read your testimony, Ms. Davidson, and it is really very compelling. Please proceed in the manner in

which you are most comfortable. I think we will hear from the boys when you are done.

STATEMENT OF LYNNE DAVIDSON, ACCOMPANIED BY EPHRAIM DAVISON, ANDRE DAVIDSON, AND JOHN DAVIDSON

Ms. LYNNE DAVIDSON. Right. I just want to say that I am the mother of these three young men here. I have Andy, a 13-year-old, and John and Ephraim who are 12. All three of the boys have hyperactivity attention deficit disorder, but John and Ephraim also have a variety of other severe emotional problems, which, as is typical with this age group, really are very hard to define and diagnose. Most of what has been offered is maybe this, maybe that, mostly deferred. We will wait to see when they grow up.

But the earliest impact of their problem is on home life. Normal behavior management techniques don't work with the types of problems that they have.

And as a single parent, it became increasingly difficult to perform my tasks while literally physically restraining one child or another. As the boys grew, their behavior deteriorated. Their first school year saw for each twin two school placements, four after-school programs, two psychiatric hospitalizations, referral to child protective service, and finally placements in a residential treatment center.

At that time, we simply could not access community-based services for these children. There wasn't anything for that age group. What was available was very limited for even older youth.

The costs of these services, especially the 16 months that they spent in residential treatment and then the 15 months in foster homes, was staggering. I believe it was $60,000 a year for each child at the time. But even those figures don't include the cost of agency staffing, phone calls, travel time, my lost wages, car maintenance, mental health of mine.

My written testimony does elaborate on the interventions of the various systems which have served us, special education, foster services through Department of Social Services—there are a lot of them. I can't keep track of them all. But I also mention the Commonwealth of Virginia's Progressive Comprehensive Services Act, which has just come into bearing on our case this past July and has provided an enormous amount of flexibility that was not really available to us to tailor treatment to what is needed and has really proven to be very cost effective.

We now hire two college students for six hours a week each to work with the boys, and that beats residential all to blazes.

I would like to let the boys speak for themselves. I think they have the best insight as to what it is like to deal with these situations. Ephraim will go first.

Mr. EPHRAIM DAVIDSON. Having a mental illness makes me real depressed and hyperactive. It makes life harder. I want to be normal. I don't want to have hyperactivity. I get jealous of others kids who have better lives. I get jealous of my brother Andy who didn't have to go to special schools. I have trouble controlling my anger and have outbursts. People don't like me. They stay away from me.

The hard things about my mental illness have been feeling that things aren't fair—living with foster families, being in hospitals and treatment centers.

The good things have been helping me get a grip on life, pull myself together, get my thoughts straight and my actions under control.

Mr. ANDRE DAVIDSON. I have to live with being hyperactive but I haven't had the other problems my brothers have. Having brothers with serious problems is hard. They don't have as much homework. They misbehave and don't get homework. I behave and get homework. It is very hard to live with them. They fight, curse and don't listen. It is like a civil war. It is hard on me, it is hard on my mom, it is hard on everybody.

Mr. JOHN DAVISON. I want people to figure out how to deal with health care reform. I would like people to take me for what I am. So what if I am emotionally disturbed? Martin Luther King, Jr., was a black man a long time ago when only whites were supposedly important. But he changed all that. And that means I can change the way people act against other people like me.

I want the people who decide what happens in the health care reform to pay for our bills and keep everybody healthy, and that includes homeless people. And I want more laws to protect all animals.

[The prepared statements of Ms. Davidson and Andy, John, and Ephraim Davidson follow:]

Testimony of Lynne Davidson

It is challenging to take a decade out of a family's experience and condense it into a manageable summary. However, it is the very mundane, daily routine which best reflects the reality and pervasive impact of a child's mental illness on the child, the family, and the community at large.

I am the mother of three young men who all suffer some degree of mental illness. The oldest, Andy, is clinically hyperactive and suffers an attention deficit disorder. Both of his brothers, identical twins, have the same attention deficit hyperactivity disorder, but they also have other emotional disorders. While psychiatric diagnosis is done tentatively when dealing with children, various diagnoses have been suggested. John has been diagnosed at different times with conduct disorder, obsessive-compulsive disorder, or the diagnosis has simply been left blank. Ephraim has been diagnosed with depression, oppositional syndrome, obsessive-compulsive disorder, or the diagnosis has simply been 'deferred'.

There is a significant family history of manic-depression, hyperactivity, learning disabilities, and drug and alcohol abuse. Behavior problems showed up early, especially with John. By the time he was three, day care workers were telling me that John was unresponsive to normal interventions, and seemed to have a lot of trouble getting along with his peers. The recognition of his problems coincided with an escalating depression on my part, and all three of the boys wound up in foster care for five months (they were four and five at the time.) During that placement the Department of Social Services found that the foster family was also experiencing significant behavior problems with the twins.

Over the next several months, John was tested and diagnosed as ADHD, and severely emotionally disturbed. The schools conducted their own testing and confirmed some of the findings, but offered no special placement. The twins' first year of kindergarten turned out to be an escalating fiasco of inappropriate behavior, noncompliance, fighting, throwing chairs, and other disruptive behavior. It was suggested that they were not ready for first grade, and they were held back that year.

After this first foreboding year, we moved to Richmond, Virginia (from Northern Virginia.) The twins repeated kindergarten, and while there were problems in the classroom, and even more at home, they managed to make it through the year. By late spring, however, it was obvious that their behavior was again deteriorating.

In the meantime, Andy was having difficulties in the classroom, moving around unnecessarily and disturbing his classmates. Because of the behavior problems with his brothers, and the possibility that he too would develop these problems, it took us several months to discover that he needed glasses.

In the summer of 1988, when the twins had completed this second year of kindergarten, I was able to arrange developmental testing for all three boys. I was fortunate to be able to access this testing through my contacts at the medical center where I work, since this service was not covered by my insurance program. All three boys were confirmed as attention deficit hyperactivity disorder. John and Ephraim were more severely affected than Andy, but all three were referred for medication and psychiatric treatment. Unfortunately, psychiatric provisions through my insurance plan were very limited.

However, one of the most useful characteristics of the twins was that they were neither timid nor polite. Their actions could not be missed or ignored. As first grade began, there were explosive outbursts in the classroom, and aggressive and non-compliant behaviors at day care. By the middle of September the twins had been dismissed from two daycare centers, and the school had been in contact with me over their classroom problems. Behavior management at home had deteriorated into an armed stalemate. Crisis could no longer be denied, and the twins were hospitalized in a private psychiatric facility.

My insurance offered 30 days of inpatient coverage, and there was a whirlwind four weeks of visits, family assessment, social and medical histories, shock simply at the concept of having two six-year-olds in the hospital, and a seven-year-old who needed to know what was happening to his routines, and his brothers. The critical issue for those four weeks was to identify resources to meet the twins long term needs once they were discharged from the hospital.

Their psychiatrist was unfamiliar with community resources for such young patients, but he and I were both optimistic. The twins were discharged in October and went back to school.

The school immediately began proceedings for the child study team to determine appropriate school placements. In the meantime, two more day care centers dismissed them, and the doctor and I discovered the harsh realities of non-existent

treatment services and lack of funding for family support services. By mid-February, two more day care centers later, both of the twins were back in the hospital. They were now seven years old.

Fortunately, at the end of the previous year, I had been able to change insurance from an HMO to a very basic Blue Cross package, without a pre-existence clause. While the services for typical childhood health concerns were limited, the psychiatric benefits were extensive, flexible, and substantially more accessible. While this insurance provided us with 120 days of psychiatric hospitalization to work with, it still offered no solution to the variety of services needed after discharge. The schools had found workable placements for the twins, but after-school care, respite care, parenting assistance, and other such services were still undiscovered.

As we had learned with the first hospitalization, insurance benefits listed and those actually authorized were not the same thing. After 40 days of hospitalization, the insurance refused to authorize further days. The hospital, recognizing the severity of the situation, held the boys three more weeks, gratis.

In the meantime, the doctor had no recourse but to state that he could not release the twins to home as long as external support services were not available. The Department of Social Services, which in January had been unable to finance respite care to keep the twins at home, took custody of the them and accessed funding to place the twins in a residential treatment facility two hours from home.

At this point, our family entered a new phase. Things were certainly more peaceful at home, but it was difficult to appreciate the change since much of my time and Andy's was devoted to commuting 110 miles each way for the Wednesday night parent support group and visiting hours, or the Sunday afternoon visiting hours. After a few months they were able to take home visits every other weekend, which meant two round trips on those weekends.

Of course, the chaos of the previous two years had take its toll on Andy. The schools tested him and put him in their gifted program; I put him in therapy once a week, and his fears and angers slowly stabilized or faded.

The insurance change had also given me the ability to choose my own therapist, and I found someone who had the experience and expertise to finally help me move beyond medication management to actual resolution of some of my issues.

This was the basic picture from April 1989 to September 1990. The School Department paid for John's and Ephraim's residential schooling, the Department of Social Services paid for the other residential services, and Andy and I took some time to get to know each other again.

By February 1990, John and Ephraim were ready for discharge. While they had made significant improvement in some of their more disruptive behaviors, the residential setting had contributed some social problems. Having lived so closely with other seriously mentally ill children, they had absorbed a whole new set of problems. Their language would stun a sailor; they had learned about sexual abuse, with details; their perceptions of other children were biased toward fear, distrust, and unpredictability; adults were not people to be close to, rather people who showed up for brief interviews during the week, or people who physically restrained you. John and Ephraim were now eight.

These social skills provided a whole new set of problems for schools and day care centers. Rather than bringing the twins directly home from the residential treatment center, an intermediate foster placement close to home was suggested. Unfortunately, a therapeutic foster home, while ideal, was not available through the county. Current foster parents were either overburdened already, or not suitable for the twins. Group homes did not take children that young. It took six months and a television news program to find a family to take them.

Once in a foster home, the twins were able to attend special programs run by the county school system. The following summer, a new after-school program began for children at risk of hospitalization. Social services was able to provide funding for John and Ephraim to attend this program. Psychotherapy and medication control were provided through medicare (medicaid?).

With both the school and the after-school needs met, it was possible to prepare for the twins to return home to live. In December 1991 they came home. They were then nine years old. The first half of 1992 went relatively smoothly, but then summer appeared. All-day programs for emotionally disturbed nine-year-olds were still not available in the community. I tried a regular all day program, explaining the situation and potential problems to the director. It lasted almost three weeks. The social worker was able to connect me with a woman who had experience with an emotionally disturbed son, and was interested in taking on such other children over the summer. Ephraim did very well (her son had been in his special class). John struggled but only made it to the beginning of August. By then it was clear that John needed a more therapeutic environment. My insurance provided coverage for partial hospitalization programs, but the only such program they had

approved was thirty miles away. So for the last eight days of the summer I commuted thirty miles to the hospital, dropped John off, and went thirty miles back to my office. At night I made the sixty mile round-trip on my way home.

Finally school was back in session. But John couldn't pull things together. By the middle of September he was back in the hospital. This time, however, he qualified for their long term partial hospitalization program, and stayed there for seven months. I still don't know who paid for that time, or if I still have a final billing to look forward to. Insurance certainly didn't cover that program.

While the partial program was helping John, Ephraim was deteriorating in his school placement. His outbursts accelerated weekly. I succumbed to the stress and wound up in the hospital (after a two day battle with the insurance company) in February 1993 for a brief psychiatric assessment and medication adjustment. Ephraim climaxed his outbursts at school that week, and the police were called to the school. Two days after I was discharged, Ephraim was hospitalized. Again insurance fought the need, and refused authorization. He was hospitalized anyway.

After discharge, he was moved to John's old school. John was busy escalating out of this partial program, and was finally sent back to his previous school - where Ephraim was now enrolled.

The remaining two months of school were a comedy of errors, with both John and Ephraim competing against each other, and then defending each other against their classmates. The police were called in again to explain possible consequences to the twins.

During the previous three years (1990 on), the Commonwealth of Virginia had been engaged in re-evaluating the ways in which services were provided to children at-risk for residential placement. The costs of residential treatment had been climbing rapidly, and the cost effectiveness of alternative community-based services was increasingly appealing. This study culminated in the passage of the Comprehensive Services Act for At-Risk Youth and Families. [More details about the Act itself and its implementation are included in the appendix.] Basically, it provides increased flexibility in funding interagency services, and encourages creative community-based solutions to individual needs.

The Act was implemented in January 1993, and funding became available in July 1993. Through this funding stream it became possible to access funding for summer programs for John and Ephraim, without custody rights being lost. Ephraim was later accepted into the partial hospitalization program which John had tried. The funding stream also allowed us to hire two college

students to work one-on-one with the twins as 'big brothers' and to provide respite for me on a weekly basis.

While this past fall has been a significant improvement over the past, there is still a long way to go. John's school, in desperation, pressed charges against him in November for vandalism and physical assault. He was sentenced to supervised probation,but the shadow of a detention center placement still lingers as he struggles for control. Ephraim will graduate from his program at the end of this month and move into a self-contained class at the local middle school. Andy - the lost sheep of the family - tolerates his brothers, and somehow maintains, through all the confusion, a toe-hold on the honor roll. I smile more than I used to, and wonder about what lies ahead.

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When I was invited to provide this testimony, I was asked to address the reality of children's mental health issues, and how these issues impact on the spectrum of services which address children's issues. As you can see from the previous history, John's and Ephraim's issues have embraced mental health, social services, education, and the justice system, in an ongoing relationship.

Their issues have also dictated much of the course my life and Andy's have taken. I settled for lower paying jobs where I had the flexibility of responding quickly to the ever present school or day care crises. My accumulated leave stays perilously low due to the constant drain from doctors' appointments, school meetings, and service planning sessions. My social life is limited - by the constant demands for my attention, by the cost of sitters who are qualified to deal with some of the challenges which the twins' behaviors can present, and by the hesitancy of many people who feel overwhelmed just being close to the situation.

Andy has had to deal with explaining his brothers' behaviors to friends he might want to invite home. He's learned to be a peacemaker, but feels trapped in that role. He has anger and resentment over the amount of time and attention John and Ephraim receive - the classic situation of the prodigal son and his older brother. At the same time he has a legitimate disorder of his own,clearly identifiable, but for years viewed by many people providing services to the family only as 'less severe than his brothers.' He has had to fight for medication, therapy, and identity.

From a broad perspective, children's mental health issues impact on every area of society: individual potential and capacity; family resources like finances, recreation, employment

potential; community services - the special education and resource areas of the schools, mental health, child protective services, welfare services, foster care, police, juvenile courts, day care, recreation programs. The list goes on.

Perhaps the best summary is to hear from the youth themselves. [Suggested order: Ephraim, Andy, John]

Ephraim Mark Davidson

Having a mental illness makes me real depressed or hyperactive. It makes life harder. I want to be normal, I don't want to have hyperactivity. I get jealous of other kids who have better lives. They don't have to go through leaving a girl friend at the treatment center, living with a foster family where I can't see my Mom as much. I get jealous of my brother Andy who didn't have to go to special schools. He already knows what public schools are like. He didn't have to leave home.

I'm smart. But I get easy words in spelling. Most of the time I'm around kids who aren't as smart as me. I'm interested in different movies than most of the people at my school. I don't like sports, but I like science. I have trouble controlling my anger, and have outbursts. People don't like me, they stay away from me.

The hard things about my mental illness have been feeling that things aren't fair, loosing my Dad and then him dying, falling in love and not being able to keep in touch with her, living with foster families, being in psychiatric hospitals and treatment centers (where I'm away from my Mom more than most kids), living with depression, love, hate, pain (like getting in fights which I usually loose, or getting restrained.)

The good things have been helping me get a grip on life, pull myself together, get my thoughts straight and my actions under control. Falling in love helped me with respecting women.

Things that would have helped me would be getting to know where Brandy went and being able to keep in touch with her, and not being afraid of people beating me up.

Andre Lucien Davidson

I have to live with being hyperactive, but I haven't had the other problems that my brothers have. The hyperactivity is great in soccer, but in school I don't really want to be hyperactive - it's hard to control without medicine, and it's bad news when my teacher's had a bad day.

Having brothers with serious problems is hard. I remember the drives to Lynchburg. And then they don't have as much homework - they misbehave and don't get homework; I behave and do get homework. It's very hard to live with them. They fight, curse, don't listen (intentionally). If they're doing or saying something and you ask them to stop, they finish anyway. It's like a civil war.

It's hard on me, it's hard on my Mom, it's hard on everybody. But then we did get to know a new family, their foster family. I wonder what it was like being in the hospital and at the treatment center. I know I visited, but I don't remember a lot about those places.

John Joseph Davidson

I want people to figure out how to deal with health care reform. I would like people to respect me; I would like people to take me for what I am. So what if I am emotionally disturbed. There was a movie called Mantis and the main character couldn't use his legs. That didn't mean he wasn't important.

People treat me like I'm nobody special or like I'm dirt. Martin Luther King Jr. was a black man a long time ago when only whites were 'supposedly' important. But he changed all that. And that means I can change the way people act against other people like me.

I want the people who decide what happens in the health care reform to pay for our bills and keep everybody healthy, and that includes homeless people. And I want more laws to protect animals.

Mr. MILLER. Thank you.

Ms. Davidson, in reading through your prepared statement, you said at the outset that many of the services were not accessible to you. It doesn't take long in reading your testimony to understand that you were dealing with the system here, that there was something in place where you were trying to come in through the front door, but that you were obviously in constant search of some kind of appropriate care.

Whether it was school, after school, childcare, whatever the institutional base may have been, there was just this constant, rather frantic search for appropriate services for your sons. Is that——

Ms. LYNNE DAVIDSON. Certainly, that is correct. There isn't any system per se, really. Most of the time when I was first dealing with things, it was either contact with the schools, who really had not experienced this type of—the school system in general may have experienced it, but any given elementary school certainly didn't know this type of behavior. It was an exception, definitely an exception to them, and they would have been the first referral source. They had no idea what community services there were available there.

Health care provided for private hospitalization, so we didn't have to go through the community health services, but again, we wound up with private practitioners who outside of their insurance-based services had no idea what was available.

Social services came in to try to provide some things like respite care, but they were not structured to really deal with emotional problems, they were more geared towards family issues. There really weren't the parenting needs they were accustomed to. We had gone through all that when they were very small, and it still wasn't working.

So everybody was really trying to say somebody else should be involved, and not knowing who it was, where to access it, how to access it, and the few things we could come up with at the time—respite care for the family was a big one—could not be funded through normal funding procedures.

Mr. MILLER. So this wasn't a case where they were handing you off to a better informed provider or an appropriate provider; they were similarly handing you off in the hopes that somebody may have a better idea?

Ms. LYNNE DAVIDSON. I felt very confident in the people I worked with. They were very knowledgeable in certain areas. They went out of their way and certainly worked overtime to try and find things. They just didn't know where to look.

Mr. MILLER. In the testimony following there is some concern expressed by one of the witnesses about the ability to get an appropriate diagnosis, that somebody who is skilled enough to put together an appropriate plan for treatment and/or for care, that also, if I read your testimony correctly, that also is a problem with you, in that some people simply didn't know what they were dealing with or did not have a basis to make a reference.

Ms. LYNNE DAVIDSON. They didn't have that basis to make a reference. There was speculation by some doctors but it was constantly. We don't have the studies on children's mental health issues long term enough to tell us where it is going.

But I also found working in the system that with three small boys and as a single parent, it was very quick and easy for people to come to the conclusion that I have problems: The home is a stressful area, this is normal behavior for children in a stressful home, let's treat the parent. And it really took a foster placement for them to be able to say, Hey, these other families who are trained can't handle these boys either, let's look at them.

It is very hard to convince people that behaviors that parents see every day and just know intuitively aren't quite right, a doctor who sees them once an hour doesn't have that insight into it. It is very hard to say, Here is a child who needs immediate help or they are going to wind up in the hospital when they are out on the swing the next day.

If you have a child with an asthma attack or a broken leg, it is concrete and visible and seriously impacts their behavior. But, you know, these kids can go play with others and do a lot of very, very normal things, but there is going to be that one time when something explodes or something backfires. You can go for months without it happening, or at least lately. It has been very nice.

Mr. MILLER. You make several references to the role of insurance as you changed plans at one point during treatment that allowed you to have some extended benefits for the boys. But again, there is—at least I came away feeling that the totality of services that you needed, insurance really wasn't much of a factor. It really was not a role, because most of those services were outside the traditional insurance base system, other than the in-patient treatment.

Ms. LYNNE DAVIDSON. Right. Insurance would cover, theoretically, weekly visits to a therapist, medication control and hospitalization. When did I access a more—a service which provided more insurance, they were simply more of the same.

Over the five years I have been in that insurance plan, you can see changes where they have come out with coverage for partial hospitalization, day programs. But at the same time they have turned around and put in a health care management system so somebody who sits in an office building looks at a doctor's one-page report and says yes or no to certain services.

So I have Ephraim transitioning into a new school next week and they recently cut back his therapy sessions so while he is in a very stressful situation, we are fighting insurance. That might be nice, we can get it resolved in three or four months, but that doesn't help him right now. So we wind up with a crisis or a need to rehospitalize or a medication emergency or something which isn't an effective way to treat this.

Mr. MILLER. That is available to you now under Virginia's new program. How does that compare?

Ms. LYNNE DAVIDSON. In terms of the hard-core insurance issues, the hospitalization and ongoing treatment, those aren't really covered by this. What this is geared to, what it is dealing with is taking a situation like ours and working over a period of a year or two, whatever it takes, really, to ensure that the services needed are in place. It is like they are the big case manager.

Mr. MILLER. So you have a case manager at this time?

Ms. LYNNE DAVIDSON. They can also provide all the little pieces to make it work, things like—we have wonderful school placements

for the boys, and we have got them in therapy and things like that, but there is still a time of day between when they get out of school and I get out of work when they are uncovered. That has been very difficult to address that. There are very, very few programs for emotionally disturbed children.

Mr. MILLER. Is there more stability in the services now provided in terms of the boys? I mean, again, there is just sort of this constant turmoil and change over the last 10 years. Is it a little bit more stable now?

Ms. LYNNE DAVIDSON. It really is. Part of it I think is a credit to the boys who have simply been very outgoing and personable in spite of their problems. I have seen people drawn to wanting to help them. So we now have a case manager who is aware of what the school is doing and what mental health is doing and what this juvenile system is doing.

So all of those services know who they can contact for information. You don't have third and fourth-hand information and guesses and types of things there. So it is much easier to stay stabilized with it, and to sit down with representatives of each group and say, Where do we want to go from here, where do we think these boys need to be, and to plan for those needs.

Mr. MILLER. So what did you guys think about these changes going on in your first few years of school, in and out of school and after-school programs?

Mr. EPHRAIM DAVIDSON. I thought it was hard.

Mr. MILLER. Make it difficult to make friends?

Mr. EPHRAIM DAVIDSON. Yes.

Ms. LYNNE DAVIDSON. Most of the children in these types of program are children with severe problems. The peer interactions can be very stressful.

Mr. MILLER. Any other comments from you guys? Pretty outspoken here. Do you think it is better now that you have a couple of college students working with you now to spend time? Is that helpful?

Mr. JOHN DAVIDSON. Yes.

Mr. MILLER. What kind of things do you do with them?

Mr. JOHN DAVIDSON. Sometimes we go to movies or go to his house. Plus he takes us to scouts.

Mr. MILLER. Does that give your mom a bit of a rest here?

Mr. JOHN DAVIDSON. Yes.

Mr. MILLER. She deserves it.

Mr. JOHN DAVIDSON. Yes.

Mr. MILLER. Sounds like full-time work here. That is good.

Mr. JOHN DAVIDSON. And she doesn't come to scouts with us. She has class on that day.

Mr. MILLER. Marge?

Mrs. ROUKEMA. Thank you.

I must tell you, Ms. Davidson, I haven't read your testimony yet, but I certainly shall. And the Chairman has asked a couple of the questions that I wanted to ask, but let me explore it with you, and I will try to restrain myself, because I have been accused for many years of practicing without a license.

I have some questions about the treatment modality here, particularly the fact that you hadn't made any reference to medica-

tions that are rather common, drug therapy that is rather common in young people. But that is not the important thing here. The important thing here is the question about insurance coverage, and there is no question but that managed health programs have cut back dramatically on all kinds of psychiatric treatment, and especially this kind.

But what astounds me here, and maybe the new Virginia program is going to help fill in those—is catching up, but I am astounded that you were either in a school system or a community State system that didn't have more help for you. Compared to what I have been familiar with, this sounds absolutely archaic. And I am sorry to hear that.

But do you now feel under your case manager program under Virginia law that you have a kind of a community mental health system that gives family counseling, family therapy, in the context of the community and school operations? Are you now getting that?

Ms. LYNNE DAVIDSON. I am aware that the way they have structured the setting does provide that. We are still accessing the mental health services through my insurance. So that part is covered with medication control, weekly therapy and hospitalizations. But I still have the case manager, even though we don't use the county's services that way.

Mrs. ROUKEMA. But you do have medical care through your insurance program?

Ms. LYNNE DAVIDSON. Yes, I do.

Mrs. ROUKEMA. Coordinated?

Ms. LYNNE DAVIDSON. No, they don't coordinate it. That is just what they provide.

Mrs. ROUKEMA. Tell me a little bit about how it works. Because the insurance program is the key part of this for our purposes, not totally for yours but for our purposes in terms of its relationship to the legislation we are considering, and the parity that we want for mental health services. Tell us presently how you have the service available through your insurance coverage and it is being better coordinated.

Ms. LYNNE DAVIDSON. The coverage from the insurance is in my view not being better coordinated. I do have a case manager through the county system to whom I say, This is what the insurance is doing and this is what they have authorized for the next three months or whatever.

Mrs. ROUKEMA. But you have your own doctor and the doctor has followed through with the treatment, on a continuum?

Ms. LYNNE DAVIDSON. They each have their own therapists. It isn't necessarily a continuum because we keep walking through different services. Once we step into a partial hospitalization program or something, then——

Mrs. ROUKEMA. I understand that.

Ms. LYNNE DAVIDSON. We have switched away from what my insurance will deal with.

Mrs. ROUKEMA. It is coordinated.

Ms. LYNNE DAVIDSON. No, my insurance doesn't have anything to do with that.

Mrs. ROUKEMA. But somebody coordinates it, whether you are going to go to a hospitalized setting or the community mental health program or the school coordinated services?

Ms. LYNNE DAVIDSON. Right. That is what is being done by the community services board type of structure.

Mrs. ROUKEMA. Good.

Ms. LYNNE DAVIDSON. They just never talk to the insurance people.

Mrs. ROUKEMA. That is quite a leap forward, then, for you.

Ms. LYNNE DAVIDSON. Yes. They have been able to leave the insurance part where it is and fill in the gaps.

Mrs. ROUKEMA. Good. And the hospitalization program, has there only been one hospitalization? Has there been more than one?

Ms. LYNNE DAVIDSON. Many hospitalizations.

Mrs. ROUKEMA. I would suggest that you are really quite fortunate in that regard, to have your insurance even helping you with that.

Ms. LYNNE DAVIDSON. Now, they have refused to cover some of them.

Mrs. ROUKEMA. Oh, did they?

Ms. LYNNE DAVIDSON. Yes. Ephraim was in the hospital this past February and they said, No. We want him in a day program and we are saying, but he has a problem at home at night.

Mrs. ROUKEMA. Who is the we that is saying? The doctor, the therapist?

Ms. LYNNE DAVIDSON. The therapist he is working with and myself, we are saying, he needs a full-day program, and the case manager for the insurance company is saying, I don't think so. We will authorize partial program, but we will not authorize the hospital.

So the program that he is in now and the full hospitalization he was in before have no insurance coverage. These are hanging over my head.

Mrs. ROUKEMA. Are you saying that the partial treatment rather than full hospitalization was inadequate or not convenient for you?

Ms. LYNNE DAVIDSON. It was inadequate for his needs at the time. He was not able to contain himself in the family setting.

Mrs. ROUKEMA. I see. Thank you very much. Your testimony has been very helpful.

Mr. MILLER. Mr. Hoekstra?

Mr. HOEKSTRA. Thank you very much for your testimony. I don't have any questions, but I appreciate it.

Mr. MILLER. The coordinator of the first 10 years was you.

Ms. LYNNE DAVIDSON. Absolutely. Very much so.

Mr. MILLER. You essentially were underwriting and continue to underwrite all the gaps that existed in that service, either by—you referred to job changes, about how often that took place, about the loss of working hours or the loss of promotion, the loss of pay, and for the time that you were coordinating these service. That is what was going on before you got into—before Virginia started this new program.

Ms. LYNNE DAVIDSON. Right. And I think the reason the program works for Virginia is that the parents are mandated to be part of it.

Mr. MILLER. That is good.

Ms. LYNNE DAVIDSON. It is very important.

Mr. MILLER. Thank you very much for testifying. Boys, I want to thank you very much for accompanying your mother and telling us your story and how you feel, what has been going on with you. We obviously wish you the best of luck. Thank you very much for being here.

Our next panel will be made up of Dr. Jane Knitzer from New York, Child Psychology, Visiting Scholar, New York University; Dr. Carolyn Robinowitz, Washington, DC, Senior Deputy Medical Director, American Psychiatric Association; Ms. Emily Buss, Philadelphia, Deputy Director, Juvenile Law Center; Suana Wessendorf from Ames, Iowa, President, Council for Exceptional Children; and Mr. Randall Feltman, Ventura, California, Director, Ventura County Mental Health Department.

Dr. Knitzer, we will begin with you.

STATEMENTS OF JANE KNITZER, CHILD PSYCHOLOGIST, VISITING SCHOLAR, NEW YORK UNIVERSITY; CAROLYN ROBINOWITZ, SENIOR DEPUTY MEDICAL DIRECTOR, AMERICAN PSYCHIATRIC ASSOCIATION, ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY; EMILY BUSS, ESQUIRE, DEPUTY DIRECTOR, JUVENILE LAW CENTER; SUANA WESSENDORF, PRESIDENT, COUNCIL FOR EXCEPTIONAL CHILDREN; AND RANDALL FELTMAN, LCSW, DIRECTOR, VENTURA COUNTY MENTAL HEALTH DEPARTMENT

Ms. KNITZER. Thank you.

First I want to start out by saying, thank you for having this hearing. This is very important to all of us in the children's mental health community. Congressman Miller, we appreciate your unflagging interest in this issue as well as that of the other committee members.

I have been asked to give an overview what the children who need mental health services look like, and what we have learned over the past decade about providing effective services to them, because we are not just talking—we have to use somewhat different frames of reference when we are talking about children and adolescents, than we do when we are talking about families. And then I will talk a little bit about what I think some of the implications are for health reform. And I will do it all fast.

We estimate that about 20 percent of all children have some need of mental health intervention, and 3 to 5 percent of them are seriously disturbed and require intensive interventions. These are children who are depressed or angry or both. They are the children who move around in foster care. They are the children whose families lose time and work, who feel desperate about how to access help for them. And sadly, very often they are children who do not do well.

One recent study found that within two years of leaving school, a group of children described as seriously emotionally disturbed ended up in the juvenile justice system.

The typical response to meeting the needs of these children is to separate them from their families, exactly as you just heard, placing them in hospitals and residential facilities because we do not

have alternatives in place. And it is not at all atypical for States to have nothing but residential treatment and inpatient care for the children who are most troubled. Outpatient services exist in a limited way.

The other thing that is really important in this group of children, again, you heard so eloquently, is they are involved with multiple systems, so that the insurance company or the mental health system will not work for them. We similarly have to be able to have the services work collaboratively.

Mr. MILLER. Just to interrupt you, you are saying the testimony of Ms. Davidson and her sons, we should not consider that unique?

Ms. KNITZER. Of the problems she had for the first 10 years, exactly. We did a study in 1982 at the Children's Defense Fund where we described in excruciating detail State by State the problems with the children's mental health system, and that was fragmentation, no communication across systems, not at all acknowledging the strengths of families and their wish to have their children be with them. That is basically where we are come. We have come a long way.

Over the years I have heard many stories from parents and increasingly they begin to sound better, and from the children. This is what I think we are asking you to make sure gets translated into the health care reform.

Let me just quickly go on. I would say that this is a population of children who cut across all classes, races, and ethnicities. Some of them receive care through Medicaid, and over the past decade, we have used Medicaid most creatively for this population of children, and many of the reforms have been driven by changes in Medicaid. And therefore I urge to you protect those gains in any kind of health care plan.

Some of the children fall into the category whose families have no insurance, and this is a major, major problem for this group of children. And then there are children whose families have insurance who are locked into jobs because of preexisting conditions or who lose days at work because there is no crisis management, team plan for the child. And so the insurance and the health care reform implications are enormous across classes.

What we have learned—I am going to be very brief about this—with a lot of blood, sweat, toil and tears, we have learned first of all to recognize that it is wrong to routinely remove children from their families. And we have learned how to see family strengths and build on them.

Most parents do not want their children away. Most foster parents do not want the placements to break down. When there are support systems in place to help them, the children very often can stay there.

We have learned to provide intensity of services equivalent to what is provided in the best of residential treatment, and as you know, residential treatment and hospital care is not always the best, but assuming the best, we have learned how to provide that level of intensity in the home and in schools, in classrooms and in homes, using behavioral aides, using in-home therapy.

We have learned to use day treatment dollars for after-school programs, for example, to fill in that terrible gap between the time

the child gets out of school and the parent gets home from work. And that, by the way, is a major problem.

And we have learned how to tailor services so that there can be services at a point of transition, for example. We have learned to use behavioral aides, mentors to train them, the college aides you have heard about. This provides children with disturbances experiences they cannot have with residential and inpatient treatment. They are normalizing experiences, and we are seeing the gains all over the country from them.

We have learned how to work across systems, and I think that is reflected here, in the range of systems here. Child welfare can talk to mental health, mental health can talk to juvenile justice. And the schools are beginning to be more central players in the efforts to develop more collaborative plans for children.

We have explored financing strategies. I have mentioned using Medicaid. That has been invaluable to driving a new way of funding services. We are experimenting with pooling funds, these different agencies are pooling the dollars used for mental health services from child welfare, from juvenile justice, from education, in a lesser way, and maximizing the impact of the dollars, and now we are beginning to see come capulation models as well.

We are also learning to redeploy mental health services. A number of places are turning to childcare workers in residential facilities or hospitals to use them as respite care workers. Respite care is an absolutely critical service if we are going to keep children out of high-cost residential facilities.

Children and families are the beneficiaries. In my testimony I describe two cases. There are many others. You heard so eloquently from Mrs. Davidson and her children.

Let me just briefly—I was just in North Carolina where I heard a mother who was from a reservation describe before and after. Her child was five years old. The child was hospitalized for eight months. The child had attacked or threatened a day-care teacher, was out of control, the usual. The immediate response was to put the child in a hospital.

The mother dutifully visited at least twice a week and got no help in dealing with the child, and it appeared that the child got no help either. When the child came to the attention of the one of the Robert Wood Johnson Mental Health programs for service sites, they met with the mother, they put an in-home aide with the house, they put an aide with the child who was then able to return to kindergarten. The in-home aide is no longer needed in the home. The mother has gained enormous confidence. This is a five-year-old who spent eight months in the hospital.

I should say, let me just add what has fueled this momentum, several things. One is the first system of care in Ventura County, which taught us all. One is a small Federal program called the Child Analyst Services Program, and currently the momentum has been sustained by a large investment by the Robert Wood Johnson Foundation that has funded eight sites to deliver services in the new way.

What are the implications for health care reform? I think they are very, significant. First of all, let me say I assume what I say is premised on the fact that we have universal access for health

care; that we will have mental health benefits. As you said, mental health will be treated in the same way that physical illness is treated. And that the preexisting condition will no longer be the kind of problem it has been for families.

But what we have learned in terms of child and adolescent mental health services is that we have to ensure that the package of services that is paid for is flexible, is clinically determined, and is medically necessary, and that it is clinically determined pursuant to a plan that is cross-system, collaborative, with family participation. The issue really has to do with the limits and the trade-offs. If you cannot use the dollars that are allocated for in-patient care and use them in other ways, we will go back to the system we had in unclaimed children, and if you want to know what health care reform will look like if we don't do the children's mental health piece right, read Unclaimed Children, it is high cost, children and families suffer, it is not a good investment.

And in order to get around that we have got to have flexible services and flexible dollars, and it is as simple and as complicated as that.

The second thing I think is important is that there be an understanding that we are not just talking about—and maybe this goes without saying, but I think we probably have to say it—we are not just talking about inpatient and outpatient, that is the standard sort of head set when you talk about mental health services. We are talking about support for cross-system, clinical assessments that involve families and multiple agencies. We are talking about community-based crisis intervention services.

There is nothing more important in the schools, going into the home, respite care. We are talking about case management and care coordination, where the care coordinator is known to the family, listens to the family, and also can help navigate the different systems.

We simply cannot provide good services without these kinds of things. We need to have the range of support of services that we have already talked about, in-home therapies, day treatment, school, classroom aides, et cetera, and we need to pay attention to the need for family life residential options, family foster care treatment homes, that is absolutely crucial.

Foster families serve many of these children. In one Robert Wood Johnson site, 70 percent of the children served were from the child welfare system. When we did unclaimed children, 40 to 60 percent of the children in hospitals were in the child welfare system. I have no reason to believe that is substantially different now.

We need to pay for—to create alternatives, family treatment homes, and we have some wonderful models around the country.

Third thing. Health care reform must be structured to facilitate the expansion of these systems of care. We cannot stop the momentum. Much of the debate in health care reform has been focused on how to define benefits, how to pay for them. For children, what you are hearing from me and what you heard from Mrs. Davidson is how the system is organized makes a difference. We now have models all over this country of systems of care that have in effect beat the fragmentation that is so typical, and the ineffective expenditures of money.

We have to figure out how to have health care reform serve as a vehicle to keep up that momentum. And interest is a lot of momentum. I will tell you, the Robert Wood Johnson Foundation just put a million dollars into a replication of system of care efforts. States are calling for technical assistance. In the recent proposals submitted by the States for the children's mental health services grant program, over 40 States applied.

We cannot let health care interrupt the momentum to create these collaborative systems. Health care entities must be allowed to link with these organized, specialized systems of care for a very difficult to serve and vulnerable population. And the model, of course, works work with other vulnerable populations too.

Mr. MILLER. I need to ask you to summarize, if you can, a little bit.

Ms. KNITZER. Yes, I will. Okay. There are two other things. One is that health care reform also must pay attention to the need for outreach and early intervention. We have figured out how to serve effectively the most high-cost kids. But we shouldn't be waiting until they get to that end. And so the basic health care structure has to deal with the front-end as well.

And last thing is fairly obvious, that in any oversight board or whatever structure is set up, there must be people who understand the systems of care perspective from a child and family perspective, which means having awareness not just of the traditional mental health view but of the role of education, child welfare, and the other systems.

I thank you and I will be glad to answer any questions.

Mr. MILLER. Thank you.

[The prepared statement of Ms. Knitzer follows:]

JANE KNITZER, ED.D.
FEBRUARY 22, 1994

Mr. Chairman. My name is Jane Knitzer. I am a psychologist and currently a visiting faculty member at New York University in the Department of Psychology. I have been involved in policy efforts to improve mental health services to children and families for over a decade. I serve on the Advisory Board of the Florida Research and Training Center for Children's Mental Health, and as a consultant to the Robert Wood Johnson Mental Health Services for Youth Program. I also chair a Task Force on Head Start and Mental Health for the American Orthopsychiatric Association. Over the years, I have had many opportunities to visit programs, to talk with policy makers and officials and above all to talk with many families.

On behalf of the entire children's mental health community I want to express my appreciation to you and the other Committee members for holding this hearing on the impact of health care reform on children's mental health, and for recognizing the importance of ensuring that any national health plan include comprehensive health and mental health services for every child.

I have been asked to give an overview of what the children who need mental health services look like, what we know about providing effective services to them and what the implications are for health care reform.

Who Are The Children?

It is estimated that 20% of all children need some kind of mental health intervention, and that 3-5 % have serious disabilities requiring intensive interventions. These are children who are either very depressed or very angry or both, who perform poorly in school and who cost the public, and sometimes their families dearly. Their parents lose days at work

trying to care for them; if they are in foster homes, they often move from placement to placement, and their ability to function in the community is often limited. A recent study, for example, found that for children identified by the schools as Seriously Emotionally Disturbed, within two years of leaving school (and this population has the highest drop out rate of any disability group) 44% had some involvement with juvenile justice.

The typical response to meeting the needs of the most troubled children is to separate them from their families, sometimes placing them in hospitals, sometimes residential facilities. The result is large (seemingly uncontrolled) expenditures of public dollars for treatment that cuts children off from their homes and communities. Many of these children have no access to mental health services until there is a severe crisis. Many are known to multiple systems-- special education, mental health, juvenile justice and child welfare, not just mental health, in fact, sometimes, not mental health at all. For example, it was estimated in 1982 that 40 to 60% of the children in psychiatric hospitals were children in the child welfare system; states report similar patterns today. The largest proportion of children with disabilities in residential treatment paid for by the schools are children with emotional and behavioral disabilities.

It is also appropriate to point out that this is a population of children that cuts across class and ethnicity. It includes those who are poor and receive Medicaid, those whose families lack any health insurance, and those whose families cannot change jobs, or whose care is jeopardized because of pre-existing condition clauses. It is also a population of families whose job productivity is impaired because typically there is no crisis management plan for their children except to get the parents out of work. Sometimes, one parent (usually the woman) is simply forced to stop working.

Lessons From a Decade of Reform

During the past decade, largely as a result of the pioneering efforts of Ventura County, California, the enactment of small federal program known as CASSP, the Child and Adolescent Service System Program, (formerly administered by NIMH and now) and subsequent foundation efforts, particularly through the Robert Wood Johnson Mental Health Services Program for Youth, which has funded system of care efforts in eight sites, including California, Ohio, and Wisconsin, we have learned a great deal about how to provide effective treatment and to structure the policies and fiscal practices in ways that maximize the impact of treatment dollars (Knitzer, 1993).

1) Families as Partners We have moved from the view that children with emotional, behavioral and mental disorders should be removed from their families to seeing parents as partners in the treatment process, and trying to build on their strengths and what they need. Most parents, we have learned do not want their children sent away; they do so only in desperation. When there are alternatives, that is what parents want. We are hearing this from families all over the country, individually, and increasingly in organized family support and advocacy groups, such as the Federation of Families for Children's Mental Health.

2) Reducing Reliance on Needless Out of Home Care We have learned that children do not have to be removed from their homes to have intensive treatment. Instead, we have learned how to wrap services around the children and families using in-home therapies, in-school behavioral aides, crisis intervention teams, day treatment, case management, and flexible services tailored to the specific family circumstances.

3) Working Collaboratively Across Systems We have learned that different agencies and systems can work together collaboratively around the needs of these

vulnerable children and their families through "systems of care" that provide a structure for bringing different systems-- mental health, but also child welfare, juvenile justice, education, substance abuse, health--together to target resources, to develop cross agency clinical teams and to eliminate the dysfunctional fragmentation that has hampered treatment efforts for so long.

4) New Financing Strategies We have been able to test out financing strategies that make it possible to provide very different kinds of mental health services by re-deploying resources in flexible ways. This has been done in several ways, alone or in combination: using Medicaid to support not just in-patient and office out-patient care, but a range of alternatives; pooling categorical dollars at the community level to create a pool of flexible service money; and using capitation strategies to fund and manage mental health services. Let me underscore however, that whatever the strategy, it does not mean that anything goes. The resources are managed and are delivered in response to a multi- agency, but medically necessary, clinical treatment plan.

5) Re-deploying Mental Health Personnel for Alternative Services We are beginning to see both informal and systematic efforts to use those skills in working with children with emotional, behavioral and mental disorders in new ways. In some places, for example, childcare staff from high cost residential and in-patient facilities are being hired to provide flexible non-residential services, including respite care (which from a cost perspective is key to enabling a child to remain at home), in-home services, and mentoring (that is serving as a behavioral coach, or carrying out classroom based treatment). Elsewhere, communities are providing case consultation to private providers seeking to treat children and families using a system of care approach.

In sum, we have learned that in patient and out patient treatment alone does not work for this population. We have learned to provide different kinds of treatment; we have learned to organize a specialized service delivery systems on behalf of the most disturbed children and families and we have learned to finance children's mental health services differently, and we are learning to use skilled staff differently. Children and families are the beneficiaries.

Let me give you two examples. In one state I recently visited a five year old child, who had threatened a daycare teacher with a knife was hospitalized for eight months, with no plans for discharge. When that child came to the attention of one of the Robert Wood Johnson Mental Health Services Program for Youth sites, they met with the mother, (who had driven long distances twice a week to visit the child in the hospital) and worked out a plan to bring him home. They provided an in-home therapist as well as an aide for the child who stays with him. With this arrangement and some support to the teacher, who is also a member of the team, he was able to return to regular kindergarten. The in-home therapist has recently been discontinued, and there is a plan to slowly wean him from the aide. The mother, who did have to give up her job, now enjoys being with her son, and has gained new confidence in her ability to help him, thus avoiding the cost of years of hospitalization or residential treatment.

In another Robert Wood Johnson site, a 16 year old who had been hospitalized for one year for both suicidal and homicidal threats was able, with intensive case management and support to her mother, to return home. In an 18 month transition, she was able to move from the psychiatric hospital to day treatment back to her regular school and no longer requires medication. Without these supports, there is no way this teenager could have returned home. In fact, negotiations were underway with child welfare at the time the system of care became involved.

Each Robert Wood Johnson site has taken a slightly different approach to service delivery and funding, but each is seeing similar results (Cole & Poe, 1993) Nor are they alone, Stark County Ohio, Virginia, Ventura County, and other places around the country are also creating systems of care for children with emotional, behavioral and mental disorders and finding children respond (Stroul, 1993). This marks a dramatic change from the time 1982 when I authored a report for the Children's Defense Fund entitled Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services. We too described the stories of many children and families, but few reflected the kinds of outcomes I just highlighted.

The Implications for Health Care Reform

Building on the very important assumptions of the Health Security Act-- that there will be universal access; that mental health benefits will be included, and that pre-existing restrictions will be eliminated, health care reform should be structured to use the lessons of the past decade from children's mental health reform efforts. To this end:

1) The proposed mental health benefit limits and trade offs in the Health Security Plan between in-patient and non-residential treatment should be immediately waived for children and adolescents. The focus should be on ensuring that the package of mental health services each child receives is flexible, is medically necessary, and is carefully managed pursuant to a clinical plan of care that reflects multiple systems and family perspectives.

In Unclaimed Children, we documented the high cost and ineffective outcomes of having a children's mental health system largely defined by traditional services, office

based out-patient care and in patient care. We are now documenting cost savings from the systems of care approach that relies on flexible services and flexible dollars. We cannot ignore that lesson in health care reform.

Therefore, any delay in moving directly to this approach will be more harmful to the children with emotional, behavioral and mental disorders than has been recognized. Limits on the scope and duration of benefits, and requiring tradeoffs between in-patient and less restrictive treatment alternatives will seriously undermine the capacity of states and communities to continue to provide or expand the flexible, clinically determined and medically necessary children's mental health treatment that is now meeting the goals of health care reform; better services with managed costs.

2) Health care reform should explicitly ensure that mental health dollars can be used for a range of clinically necessary services for children. These services should include, but not be limited to:

- cross system clinical assessment/ diagnostic processes involving families and multiple agencies, reflected in the utilization of a common plan of care
- crisis intervention services, (including respite care);
- case management/care coordination capacity that cuts across systems
- supportive services tailored to individual needs, including behavioral aides, in home therapists, etc.
- family like residential options for children who cannot be in their own homes, including foster family treatment homes

3) Health care reform should facilitate the expansion of systems of care for children with complex emotional, behavioral and mental disorders that are linked to health care entities.

Much of the debate about mental health care in health care reform has been focused, correctly on ensuring access and on clarifying the nature of the benefits needed. But there must also be attention to how the services are delivered, especially for vulnerable, special needs groups such as children with emotional, behavioral and mental disorders.

The pioneering systems of care that now exist serve as a laboratory for how to integrate children's mental health into health care reform. Interest in expanding organized systems of care for children's mental health, in recognition of improved treatment and often cost outcomes, is widespread. Thus, the Robert Wood Johnson Foundation has just allocated a million dollars to facilitate replications and states and communities are lining up for assistance in the conversion process. In the recent round of applications for federal dollars appropriated under the Children's Mental Health Service Grant Program, over 40 states submitted requests although only a small number could be funded.

Health care reform efforts should capitalize on this momentum, helping it to move forward, in the interests of the larger goals of health care reform. Therefore, any national health care plan should ensure that health care entities be required to link with organized systems of care for children with complex emotional, behavioral and mental disorders, and that such systems of care system of care be able to provide family focused, flexible, culturally responsive services, and involve multiple child serving systems in both its management and clinical strategies.

4) Health care reform should ensure that health care entities do outreach and early intervention in natural settings in which children are found, particularly early childhood programs and schools to forestall the flow of children with severe disabilities into these organized systems of care likely to serve the most troubled and high cost children.

One of the most consistent findings in studies examining the careers of children who have emotional, behavioral and mental disorders is that these disorders are identified early, but that treatment is either non-existent or too little. Yet we know (and research continues to probe), that early intervention can pay off both with reductions in out of home placement, and behavioral improvements. For this reason, it is crucial that health care entities, as they assume the fiscal risk for for what are often called " the deep end children" focus attention on outreach and early intervention as well.

5) Any national Health Care Board, or oversight group must include representatives familiar with emergingsystems of care for children and adolescents with emotional, behavioral and mental disorders, with non-traditional, as well as traditional mental health services, and with outreach and early intervention practice and policies.

Unless there is clear understanding at the highest levels of decision making for health care reform that effective children's mental health services requires outreach, early intervention, systems of care marked by heightened responsiveness to families, and cross system collaboration we will not capitalize on the hard won cost and treatment gains of the last decade. We cannot afford to have regressive children's mental health policies be part of health care reform. We have come too far to go backwards.

Thank you for your interest. I will be happy to respond to any questions, or provide you with any additional information that may be helpful.

Mr. MILLER. Dr. Robinowitz?

Dr. ROBINOWITZ. Thank you, Mr. Chairman. I am Senior Deputy Medical Director of the American Psychiatric Association, and a child psychiatrist. I am pleased to present testimony on behalf of the American Psychiatric Association and its 38,000 members and the American Academy of Child Adolescent Psychiatry, which has 5,600 child and adolescent psychiatrists.

At the outset I would like to acknowledge with appreciation not only your efforts, Mr. Chairman, but the personal efforts of Representative Roukema on behalf of severe mental illness, as evidenced by her sponsorship in the House of H.R. 1563, legislation to require that any health care reform bill enacted by the Congress include at least nondiscriminatory coverage of treatment of persons with severe mental illness.

Included in the American Psychiatric Association's 12 principles for health care reform is a principle that states that we will pursue relentlessly at State or Federal levels nondiscriminatory catastrophic coverage for patients with severe mental illness, irrespective of the basic defined benefit.

Representative Roukema's efforts and those of many other members of the House and Senate is clear confirmation that support for coverage of treatment of mental illness is a bipartisan issue, and I would like to thank you all of you for your support.

Sadly, discrimination against persons with mental illness is ingrained in our culture. It desensitizes the public to the reality that persons with mental illnesses are in fact suffering from illnesses, just like the millions of Americans who suffer from illnesses such as diabetes, cancer, and heart disease. By dehumanizing the victims and denigrating the illness, it also facilitates discrimination in health insurance coverage for persons with mental illness.

I think we have heard only a little bit of that in testimony today, that any discussion with anyone who in his or her family has had mental illness will tell you the very sad stories that they have had in trying to get coverage for even the most basic care.

Mental illness, including substance abuse, affects tens of millions of Americans, knows no geographic boundary, respects no income boundaries. People don't want to be mentally ill. They don't try to be, and they would just as soon not be.

But we know that 12 million children—12 million—suffer from some form of treatable mental disorder, and the systems are not always available to help them, even if the benefits are available, access to care and continuing care may not be.

Maternal alcohol abuse is the leading preventable cause of mental retardation in children. Eleven million Americans suffer from severe mental illnesses such as schizophrenia, bipolar disorder, or major depressive disorder.

One-third of the Nation's homeless persons at least suffer from severe mental disorders.

One-fifth to one quarter of people with AIDS-related cognitive dysfunction. Two thirds of all persons with AIDS will develop neuropsychiatric problems. And we have just heard that there are treatments for pregnant women that may influence the development of HIV–AIDS disorders in newborns and children.

Finally, 30,000—30,000—Americans commit suicide each year, and suicide is the third leading cause of death for individuals between the ages of 15 and 24, moving rapidly to the second leading cause of death. Among adolescents, suicide has increased by 30 percent since 1950.

Our recommendations for health care reform are quite simple, and they are based on the knowledge that effective psychiatric care is less costly than no care or ineffective care, and in the long run a cost savings both to society as a greater good but also as measured by utilization of other health, welfare, and legal care.

We urge your strong support for health reforms which end the pervasive pattern of discrimination against persons with mental illness, their families and those who treat them. Coverage for treatment with mental illness should be included as a uniform benefit in any health care reform proposal, subject only to the same limitations of scope and duration as we apply to any other nonpsychiatric medical illness.

Patients should have full access to a broad array of services based on medical necessity, offering a full continuum of care, including inpatient care, outpatient care, partial hospitalization, residential treatment, home and community services, or school-based services as the patient's needs require.

Persons with mental illness and their treating physicians and other health care professionals should be subject to the same protocols, reviews that are required of patients with no psychiatric illnesses. We just want to be treated the same.

In order to ensure that clinical needs of patients with mental illness are properly addressed, care also should be taken in any plans for the future to ensure that there is a sufficient supply of psychiatrists in general, and child and adolescent psychiatrists in particular, since psychiatrists are the only physicians specifically trained in the diagnosis and treatment of mental illness and the only mental health providers who are physicians.

There are data from GMENAC many years ago reiterated by COGME that indicate a severe shortage of child and adolescent psychiatrists.

My prepared statement includes a very detailed summary of the provisions of the leading health care reform bills as well as an analysis of their relative strengths and weaknesses in relation to psychiatric care.

Congress has a real chance now to make a dramatic improvement in the lives of millions of children, adolescents and their families who through no fault of their own suffer from illnesses which are as disabling as many other that physicians treat.

The best way, the most cost-effective way of insuring that persons with mental illness receive the care they need is to require nondiscriminatory coverage of the continuum of treatment of persons with mental illness, including substance abuse, using a flexible approach and requiring medical necessity be the ground for this treatment as it is for any other illness.

Thank you very much.

[The prepared statement of Dr. Robinowitz follows:]

Carolyn B. Robinowitz, M.D.

Mr. Chairman, I am Carolyn B. Robinowitz, M.D.. I am Senior Deputy Medical Director of the American Psychiatric Association, and a child psychiatrist. I am pleased to present testimony on behalf of both the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry.

The American Psychiatric Association (APA) is the medical specialty society representing more than 38,000 psychiatric physicians in the United States. The American Academy of Child and Adolescent Psychiatry (AACAP) is the national professional association of over 5,300 child and adolescent psychiatrists.

I would like to acknowledge at the outset of my testimony the personal efforts of Representative Roukema on behalf of persons with severe mental illness, as evidenced by her sponsorship in the House of H.R. 1563, legislation to require that any health care reform bill enacted by the Congress include at least non-discriminatory coverage of treatment of persons with severe mental illness. Included in APA's own "12 Principles" for health care reform is a principle that states that psychiatry will "relentlessly pursue at state or federal levels, non-discriminatory catastrophic coverage for patients with severe mental illness, irrespective of the basic defined benefit."

Representative Roukema's efforts, and those of many other members of this and other Committees in both the House and Senate and on both sides of the aisle, is clear confirmation that support for coverage of treatment of mental illness is bi-partisan and very strong in the 103rd Congress. I would just like to say "thank you" on behalf of our members and their patients.

Health Systems Reform and Persons with Mental Illness: The Unmet Need

The efforts of the Clinton Administration, and the continuing efforts of the Congress to reform the nation's health care system pose a unique opportunity for redressing discrimination against persons with mental illness (including substance abuse) and for ensuring -- once and for all -- that those who suffer from these illnesses have access to the care their illnesses require for effective treatment.

Sadly, discrimination against persons with mental illness is an ingrained aspect of American culture. It desensitizes the public to the reality that persons with mental illnesses are in fact suffering from illnesses, just like the millions of Americans who suffer from heart disease, cancer, or diabetes. By dehumanizing the victims and denigrating the illness, it also facilitates discrimination in health insurance coverage for persons with mental illness.

Our recommendations for health care reform are stated simply:

- *We urge your strong support for health reforms which end the pervasive pattern of discrimination against persons with mental illness and those who treat them.*

- *Coverage of treatment for mental illness should be included as a uniform health benefit in any health care reform proposal, subject only to the same scope and duration as are applied to non-psychiatric medical illness.*

- *Persons with mental illness -- and their treating physicians and other health professionals -- should be subject to the same protocols, the same reviews, and the same cost controls as are required of patients with non-psychiatric medical illnesses and the physicians and other health professionals who treat them.*

- *We recommend consideration of the development of a prioritization process for all medical services, including mental health services, based on common criteria for outcome and usefulness to patients.*

- *Patients should have access to a broad array of services offering a full continuum of care, including inpatient, outpatient, partial hospitalization, residential treatment and home and community-based services, as the patient's clinical needs require.*

- *In order to ensure that the clinical needs of patients with mental illness are properly addressed, care should be taken to ensure that there is a sufficient supply of psychiatrists, who are the <u>only</u> physicians specifically trained in the diagnosis and treatment of mental illness, and the <u>only</u> "mental health" providers who are physicians.*

More than any other medical doctor, psychiatrists know first hand about the health insurance crisis affecting the United States. As the only physician specializing in the "primary care" of treatment for persons with mental illness, we are confronted every day by the fact that many of our patients effectively have no health insurance, particularly if they suffer from "severe" mental illness, for either their physical or mental treatment.

Our insured patients face discrimination in the form of higher coinsurance or different arbitrarily established limits on inpatient or outpatient coverage duration for their mental illness than is otherwise applied to other non-psychiatric medical illnesses. Many patients because of stigma refuse to use the insurance coverage they have out of fear of being denied health insurance if they ever change jobs.

Even the Federal Government is guilty of "discrimination by diagnosis." More than 30 years after the enactment of the Medicare program, our nation's senior citizens and disabled Medicare beneficiaries must still pay out of their own pockets 50 cents of every dollar for outpatient care by a physician psychiatrist, clinical psychologist, or clinical social worker. This is direct and blatant discrimination by the Federal Government against persons with mental illness. APA and AACAP have worked for many years to end the 50 percent Medicare outpatient mental health coinsurance requirement, and we urge you to end this discrimination as part of health care reform.

Discrimination against persons with mental illness is in stark contrast to the scope and prevalence of these illnesses. Mental illness (including substance abuse) affects tens of millions of Americans, knows no geographic boundary, respects no income distinctions, and is unaffected by race, sex, or religion.

- **12 million children suffer from some form of mental disorder.**
- **Maternal alcohol abuse is the leading *preventable* cause of mental retardation in children.**
- **Some 40 million adults in the United States suffer annually from diagnosable mental disorders, including mental illness and alcohol and drug disorders.**
- **11 million Americans suffer from "severe" mental illnesses such as schizophrenia, bipolar disorder (manic depression), or major depression.**
- **One third of the nation's homeless persons suffer from severe mental disorders.**
- **One-fifth to one-quarter of persons with AIDS will develop AIDS-related cognitive dysfunction. Two-thirds of all persons with AIDS will develop neuropsychiatric problems.**
- **Mental illness is a major problem among our nation's elders. At least 50% of elderly nursing residents have a diagnosis of a mental disorder such as major depression. The suicide rate for the elderly is twice that for the general population.**
- **Alzheimer's disease is the fourth leading cause of death among U.S. adults, afflicting an estimated 4 million elderly Americans who, along with persons with other dementias, occupy more than 50% of the nation's nursing facility beds.**
- **30,000 Americans commit suicide each year. Suicide is the third leading cause of death for individuals between the ages of 15 and 24. Among adolescents, suicide has increased by 30 percent since 1950.**

Treatment Needs of Children and Adolescents:

Children and adolescents with emotional disorders have little assurance their psychiatric illnesses will be identified, evaluated, diagnosed and treated. A large part of this problem can be traced to lack of insurance or policies which discriminate against treatment of mental illness. Without adequate insurance and without treatment, children and adolescents are at risk.

As with psychiatric treatment in general, effective treatment for children and adolescents should include but need not be limited to preventive interventions, early identification, assessment and diagnosis, case management, outpatient treatment, partial hospitalization, home-based services, detoxification and inpatient treatment. Effective treatment for children requires that services involve both the child or adolescent, and family, interaction with the education system as well as appropriate collaboration with other significant care givers, teachers, physicians or providers of other needed services.

Under current Federal law, Medicaid is designed to provide mental health services to eligible children and adolescents. Medicaid's mandatory services for children and adolescents with psychiatric illnesses include outpatient hospital services -- including partial hospitalization, inpatient hospital and physician services -- and services under the Early Periodic Screening, Diagnosis and Treatment (EPDST) program. In 1989, Medicaid was amended to require the provision of treatment and follow-up services for problems identified through EPDST screening even if the state does not normally cover such services through Medicaid.

Most states have not been able to comply with the expanded Medicaid requirements, primarily for economic reasons that impede the training of screening personnel, the establishment of referral protocols, and the inability to reimburse for professional services at any more than a minimal level. We nevertheless urge Congress to protect Medicaid-eligible children from reductions in their benefits as health care reform legislation moves forward. As we expand access to health care for all, we must not undercut the current services available to low income children with mental illnesses.

As part of health care reform, in order to best meet the child's clinical goals in a cost-effective manner, incentives should encourage the use of early interventions, the level of treatment necessary, management and treatment by an appropriately trained physician, and the most appropriate treatment setting.

Managed competition may pose particular risks for children and adolescents. Competition for contracts can lead to mental health benefit packages that discriminate solely because of the stigma of the illnesses involved. Children and adolescents with psychiatric illnesses often require complex diagnoses. Comorbidity is high in diagnoses such as conduct disorder or attention deficit disorder and adjustments in the continuum of care treatment plan may be necessary. Inflexible packages can obstruct even standard treatment plans for children and adolescents. Of particular note, effective and accurate diagnosis of comorbidity requires trained physician psychiatrists, and most particularly child and adolescent psychiatrists. Improper diagnosis lengthens the requisite treatment and adds to the cost of the illness.

Utilization review of services for children and adolescent psychiatric patients can also be a significant problem. APA's extensive experience with complaints received through our 1-800 managed care "hotline" suggests that too often, child and adolescent psychiatrists find that reviewers do not have enough knowledge about treating young patients. Even medical directors, unless trained in child and adolescent psychiatry, develop treatment plan review guidelines for children and adolescents based on practice guidelines for adults.

Finally, we note that effective case management is essential to effective treatment of mental illness, and thus an essential component of health care reform. Negotiating with agencies, resources, providers, and specialists is difficult and frustrating, and delays in treatment can result. Case managers must be trained to access a wide range of services and be appropriate in referring those services.

The Health Security Act:

Mental illness is a serious health care problem in the United States. It should therefore be accorded a high priority in any health care reform plan.

The Clinton Health Security Act -- as introduced in the House as H.R. 3600 and in the Senate as S. 1757 on November 20, 1993 -- makes a commendable effort to end discrimination against persons with mental illness. Sadly, the Clinton plan will not provide non-discriminatory coverage from the outset in 1998, as 87% of Americans support according to a recent survey in Parade magazine. Perhaps the legislative process needs to catch up with constituents. The Administration has made it clear, however, that it plans to phase-in non-discriminatory coverage by 2001.

Since the President's plan must be considered as the "leading" health care reform bill -- at least to-date -- we offer the following detailed analysis of the major provisions of the Health Security Act. Since it is our understanding that there were some technical problems in the printing of H.R. 3600, this analysis follows the specific text of the Senate version of the bill, S. 1757, as introduced by Senator George Mitchell. The general outline of the Administration's health care coverage for mental illness includes the following:

1998 Mental Health Benefit Coverage Limits (S. 1757):

In general, the mental health and substance abuse provisions are as follows in 1998 (the first year the plan takes effect):

- Inpatient and Residential Mental Illness and Substance Abuse Services:

  The maximum annual inpatient benefit is 30 days per year.

Up to an additional 30 days per year "shall be available" if it is determined "in advance" by the health plan that "(i) the individual poses a threat to his or her own life or the life of another individual; or (ii) the medical condition of the individual requires inpatient treatment in a hospital or a psychiatric hospital in order to initiate, change, or adjust pharmacological or somatic therapy."

Inpatient care may be used only (i) when less restrictive nonresidential or outpatient treatment would be ineffective or inappropriate, and (ii) when provided in the least restrictive setting that is effective and appropriate for the individual.

- Intensive Nonresidential Mental Illness and Substance Abuse Treatment:

Maximum coverage is 120 days per year.

The first 60 days of care are required to be exchanged for inpatient care on a 2 for 1 ratio (i.e, the first 60 days of intensive nonresidential treatment depletes 30 days of available inpatient care). If there are less than 30 days of inpatient care available, the maximum intensive nonresidential alternative days are reduced accordingly.

After the first 60 days (or the otherwise available number) of nonresidential alternatives are used, individuals "shall receive coverage for a maximum of 60 (additional) days" if the health plan "determines that the individual should receive such treatment."

- Outpatient Mental Illness and Substance Abuse Treatment:

Outpatient treatment includes screening and assessment, diagnosis, medical management, substance abuse counseling and relapse prevention, crisis services, somatic treatment services, psychotherapy, case management, and collateral services (i.e., services to family members when an individual is also receiving mental illness or substance abuse treatment).

Coverage of all but psychotherapy and collateral services is nondiscriminatory. Coverage for psychotherapy and collateral services is limited to 30 visits per year in the aggregate.

Additional visits "may (note not must) be covered at the discretion of the health plan" provided that the additional visits "prevent hospitalization or . . . facilitate earlier hospital release".

Where offered, the additional visits must be exchanged for inpatient and residential covered days on a 4 to 1 ratio (i.e., each 4 outpatient visits reduce the available "basic" first 30 days of inpatient care by 1 day).

The additional outpatient psychotherapy and collateral services visits are "capped" by the number of unused inpatient days available to be traded-off, such that no additional outpatient psychotherapy and collateral services visits (beyond the 30 "basic" visits) may be provided once there are no inpatient days to be traded for additional visits.

Outpatient substance abuse counseling and relapse prevention is covered "if the health plan . . . determines (based on criteria that the plan may choose to employ) that the individual should receive such treatment."

When provided, visits for such services must be traded in for unused "basic" (i.e., the first 30) days of inpatient care. As above, once available unused inpatient days are exhausted, no outpatient substance abuse and relapse prevention treatment is provided.

30 visits per year for group therapy for substance abuse counseling and relapse prevention is also available, provided that the group therapy occurs within 12 months after the patient received either inpatient substance abuse treatment or intensive nonresidential substance abuse treatment. Where provided, group therapy does not count toward the 30 visit limit for outpatient psychotherapy and collateral services, nor does group therapy reduce available inpatient hospital days.

- Definition of Mental Disorder and Substance Abuse Disorder:

These terms are defined to mean a disorder that: (A) is listed in DSM-III-R (or subsequent revisions), "except V Codes for Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment"; (B) is the equivalent of such DSM-listed disorders but is listed in ICD-9, Third Edition, or subsequent revisions; or (C) "is listed in any authoritative text specifying diagnostic criteria for mental disorders or substance abuse disorders that is identified by the National Health Board."

The cost sharing features of the President's package are complex. In brief, cost sharing for mental illness and substance abuse treatment is a function of the type of plan in which an individual is enrolled, and is thus very complicated to explain. In general, cost sharing rules are as follows:

- For "Low Cost" Plans: A catastrophic out-of-pocket stop loss of $1,500 per individual and $3,000 per family is imposed. No deductibles are charged. In general, there is no copayment for nonpsychiatric inpatient acute care services and a $10 per visit charge for provider services ($25 for some services, typically provided in an emergency room).

There is no deductible and no coinsurance for inpatient and intensive nonresidential mental illness and substance abuse alternative services.

For outpatient mental illness and substance abuse services other than psychotherapy, collateral services, and case management, there is a $10 per visit charge.

For outpatient psychotherapy and collateral services provided prior to January 1, 2001, there is a $25 per visit charge, reduced to $10 per visit after that date.

For case management services there is no cost sharing.

Out-of-pocket expenses for outpatient mental illness and substance abuse services do not count toward the annual stop loss limits.

- For "High Cost" Plans: There is an annual deductible of $200 per individual and $400 per family. A catastrophic out-of-pocket stop loss of $1,500 per individual and $3,000 per family is imposed. In general, there is a 20% patient coinsurance for inpatient and outpatient services (with some exceptions).

For inpatient mental illness and substance abuse treatment, there is a one day deductible ("per episode") and 20% coinsurance. Out of pocket expenses for inpatient mental illness and substance abuse services count toward the annual deductible and stop loss.

For intensive nonresidential alternative services there is a one day deductible ("per episode") and 20% coinsurance. Out-of-pocket expenses for the first 60 days of intensive nonresidential alternative mental illness treatment count toward the annual stop loss. Out-of-pocket expenses for nonresidential services for mental illness beyond the first 60 days do not count toward the annual stop loss. Out-of-pocket expenses for any nonresidential treatment for substance abuse do not count toward the stop loss.

In high cost plans, for intensive nonresidential alternative services for mental illness and substance abuse beyond the first 60 days, there is a 50% coinsurance. As introduced in S. 1757 as printed, the 50% coinsurance for covered days beyond the first 60 days is permanent. Note that, as previously discussed, the White House indicates that this is a printing error, and that they intend for the 50% coinsurance to be reduced to a non-discriminatory 20% on January 1, 2001.

For outpatient mental illness and substance abuse services other than psychotherapy, collateral services, and case management, there is a 20% patient coinsurance.

For outpatient psychotherapy and collateral services provided prior to January 1, 20001, there is a 50% per visit coinsurance, reduced to 20% per visit after that date.

For case management services there is no cost sharing.

- For "Combination Plans": There is an annual catastrophic out-of-pocket stop loss of $1,500 per individual and $3,000 per family. In general, cost sharing rules follow the "low cost" cost sharing for services received "inside the plan", and the "high cost" cost sharing for services received "outside the plan."

Under the President's plan, by January 1, 2001, specified limits on mental illness services would be eliminated, ensuring a fully flexible plan. Individuals would thus be entitled to whatever services they required in the setting most clinically appropriate for their treatment without having to factor in trade off days or other limits.

Impact of the President's Plan:

Our response to the President's plan as introduced is very much on the order of "a glass half full." Whether the glass is half full or half empty, no other Administration in decades has dedicated so much time and effort to the challenge of health systems reform. Since enactment of the Medicare system some 30 years ago, no other President has attempted to deliver such a detailed plan for health care for Americans.

Here are some of the major positive features of the proposal:

- Coverage: Some 34 million Americans who now lack health insurance will have it.

- Guaranteed Access: All Americans will be guaranteed access to health insurance. "Job lock" will be ended.

- Preexisting Conditions: Health plans will not be able to refuse coverage because of a preexisting health condition.

Sadly, while no President in recent memory has done more to propose improved access to mental health services, the plan does fall short of our objective for our patients of non-discriminatory coverage of treatment of mental illness (including substance abuse).

The President's health care reform package falls short of basic equity for the mentally ill in several respects:

- Coverage: Non-discriminatory coverage of mental illness will be "phased-in" over a 3 year period. At the start, the plan imposes limits on treatment that are not applied to other illness.

For example:

Outpatient psychotherapy is subject to a general limit of 30 visits per year, although additional visits could be made available at the option of the plan (and only to facilitate release from a hospital or to prevent hospitalization not facilitate appropriate medical treatment) but only by reducing available inpatient care pursuant to a trade-off formula of 4 outpatient visits for 1 inpatient day;

Inpatient hospital care is limited to 30 days per year with only a possibility of an additional 30 days subject to specific criteria;

Non-residential alternatives to hospitalization such as partial hospitalization would have to be drawn down against inpatient days pursuant to a trade-off formula of 2 days of non-residential alternatives to hospitalization for 1 day of inpatient care.

- Cost Sharing: Patients will pay more out of their own pockets for treatment of mental illness than they will for other covered health services.

For example:

Patients will pay 50% coinsurance for outpatient psychotherapy, a deterrent to treatment.

For patients with severe illness who require hospitalization, the plan will require that they pay a deductible equal to the first day's hospitalization not required for physical illness hospitalization. This is a terrible burden for any patient, let alone someone who is ill enough to require hospitalization.

Patients will pay 50% out-of-pocket for intensive nonresidential alternatives to hospitalization beyond the first 60 days of such care, and will also pay a one day deductible per episode for such care. This cost sharing makes these much needed services prohibitively costly for most patients.

With the exception of inpatient care and some intensive nonresidential care, virtually none of the considerable out-of-pocket expenses required of patients being treated for mental illness or substance abuse will count toward the annual catastrophic stop loss.

- Complexity: The mental health benefits are subject to an almost bewildering array of differential coinsurance, deductibles, visit limits, and trade offs between inpatient, outpatient, and partial hospitalization.

For example:

The first 60 days of intensive non-residential alternatives to hospitalization must offset available inpatient days on a 2 for exchange.

Additional outpatient psychotherapy visits -- where authorized -- must offset available inpatient days on a 4 for 1 exchange, and are available only to the extent that "basic" days of hospital care are still available (i.e., that some of the 30 days of inpatient care have not been used).

We know from our own experiences with Medicare that despite a concerted effort, HCFA cannot today ensure that Medicare carriers are properly accounting for and reporting the impact of the 50% patient coinsurance (the so-called "psychiatric reduction") for outpatient psychotherapy under Medicare Part B.

Our experience with the health care system as it now exists does not bode well for the easy implementation and administration of the Clinton plan for mental health and substance abuse, and we are gravely concerned about retrospective efforts to have the treating professional reimburse the alliance for disallowed services.

Impact of the President's Plan on Children:

The benefits and limitations of the impact of the President's health care reform plan on children and adolescents generally follows the problems outlined for coverage of treatment of mental illness in general. Some specific issues include:

Inpatient and Residential Mental Illness and Substance Abuse Services:

The limited benefit in the transition period inappropriately defines the treatment plan needed to stabilize, diagnose, and treat the seriously mentally ill child or adolescent. For example, 30 days is a not only arbitrary but also unnatural limit for the most intensive type of children's mental illness treatment. Children and adolescents with a mental illness seldom need hospitalization, but when they do, it is extremely serious. A limited mental illness benefit for a seriously ill child obstructs successful, long-lasting treatment.

Inpatient hospitalization and residential treatment are designed to treat children with severe disorders. Such problems can be acute, such as suicidal behavior, or chronic, such as infantile autism. Sometimes, factors other than the severity of a child' mental problem -- such as extreme weight loss due to anorexia -- may indicate the selection of a relatively intensive setting. More intensive settings may be chosen when children's support systems are insufficient, their home environment is deleterious, or other treatment resources are lacking.

Current treatment experience dictates that the length of stay in a residential treatment center (RTC) ranges from a few days to a year or more. Most RTCs (over 80 percent) treat children for a period ranging from several months to 2 years. A 30 day benefit, even with a waiver for 30 more days, falls far short of what is useful for the intensive individual therapy combined with continued education, family collaboration, and re-entrance into the community. As more community-based services become available, the length-of-stay may shorten, but the Administration's plan for capacity building is far ahead of what is available for children after the benefit runs out.

For substance abuse, the coverage of only detoxification is inappropriate for children and adolescents. Treatment plans must have the ability to set services according to individual needs not according to a minimum level of functioning. Substance use and abuse often occur in association with medical and mental disorders, homicide, accidents, suicide, family dysfunction, antisocial behavior and violent crime. The coexistence of substance abuse, psychiatric illness (dual diagnosis), and medical illness (triple diagnosis) amplify the magnitude of the problem for patients and psychiatrists.

Reduced mental health benefits, fewer specific provisions for alcohol treatment, the shift from inpatient to outpatient day treatment settings, and the advent of managed care and other cost-cutting tactics have brought new challenges to the role of the child and adolescent psychiatrist in the assessment, management and treatment of these problems. The Administration's health care reform bill continues these challenges when it could remove them.

Intensive Nonresidential Mental Illness and Substance Abuse Treatment:

The limited number of days proposed in the Clinton plan is a barrier to the treatment of children and adolescents with a mental disorder serious enough to call for intensive non-residential treatment.

Partial or day treatment is often used as a follow up to hospitalization or RTC treatment, when a child may no longer need 24-hour care but is not yet ready to cope with a regular classroom. Some children need the treatment offered in the hospital setting during the day but will be able to return home in the evening. The treatment program for these children should be identical to the daytime treatment program of the inpatient children.

The obvious problem with limiting the number of days this benefit is available is the increased chance of rehospitalization. It is not good medicine to force treatment goals to an artificial time limit of 60 or 120 days. The irony of this possibility is that the benefit is designed, "only for the purpose of averting the need for, or as an alternative to, treatment in hospitals or residential inpatient settings".

The even greater irony is the expectation that 120 days will allow seriously emotionally disordered children and adolescents to be restored to functioning at a level where support services can be accessed for maximum functioning in the community. Adults moving from inpatient to intensive non-residential will have difficulty reaching this level in the allowed time. For children diagnosed with conduct disorders, eating disorders, or suicidal behaviors with substance abuse, 120 days is not going to assure proper treatment or continued success beyond the benefit limit.

Out-of-pocket costs are another major barrier to care. While a sliding scale for copayments is provided for children and adolescents, we are concerned that the overall costs may become prohibitive at either a 20% copayment (for the first 60 days) or a 50% copayment (for the second 60 days, where available). For example, an average partial hospitalization costs approximately $450 per day. With a 50% copayment this service will require out-of-pocket payments totalling $13,500 for 60 days of care.

Outpatient Mental Illness Treatment:

Children and adolescents need far more collateral visits than adults. If teachers, family members, and other caregivers are to be brought into the treatment -- as they should for effective treatment of children -- the 30 visit annual limit for outpatient psychotherapy and collateral services is inappropriately low and does not adequately reflect the extended, complex needs of children. The limited benefit impedes successful treatment and contributes to costly chronic illnesses that cause developmental delays and constant family disruptions.

As with the copayment for intensive non-residential hospital alternatives, the 50% copay for children is exorbitant, even with a sliding scale to assist those with little or no income. Care givers will be reluctant to access the benefit until more serious symptoms are manifested, perhaps even beyond those symptoms which might provide a medical indication that treatment is needed.

We agree with the President's comments that "we can no longer afford to continue to ignore what is wrong" with our health care system. For the millions of Americans who struggle every day with mental illness and substance abuse, what is wrong is that they are treated differently just because of their diagnosis. We respectfully disagree with the way the President has phased-in his prescription for change.

Coverage of treatment for cancer -- in children or adults -- is a given in health care reform. So is coverage of treatment for cardio-vascular problems, diabetes, and the flu. Why then is it acceptable to limit or otherwise discriminate against children and adults who have, through no fault of their own, psychiatric illnesses? As physicians, our medical prescription is to improve the President's -- or indeed any health care plan by treating persons -- including children -- with mental illness with the dignity and compassion they deserve. This can best be done by ending any artificial distinctions between the coverage of psychiatric illness and other medical illness.

In addition to determining the scope, duration, level, and type of benefits to be included in health care reform, the Administration and the Congress will also have to consider a host of complicated issues outlined below.

Mental Health Trade Offs:

The President's proposal includes provisions which attempt to provide "flexibility" in the mental health benefit, but which in fact -- unfortunately in our view -- represent a retreat from the both the initial benefit package laid out in the September 7, 239-page draft and the October 27 legislative draft.

For example, the Health Security Act as introduced:

- Reduces (from earlier drafts) the inpatient hospital benefit (from 60 days per year to 30 days per year with only the possibility of up to an additional 30 days).

- Requires intensive non-residential alternatives to hospitalization to offset available inpatient days on a 2 for 1 exchange, which would reduce available non-residential days if less than 30 "basic" days of hospital care were available to be traded off.

- Requires significant cost sharing (i.e., one-day deductible and 50% copayment) for any days of intensive non-residential alternatives which are not traded off against inpatient days.

- Reduces the outpatient psychotherapy and collateral services from an annual aggregate limit of 60 visits (30 for each service) to an annual aggregate limit of 30 visits for both).

- Limits additional outpatient visits beyond the 30 visits to those that are provided at the option of the plan, and then only to prevent hospitalization or to facilitate earlier release from a hospital -- rather than to facilitate appropriate medical treatment for the patient in accordance with the treating physicians judgment, and then at a 4 for 1 trade off for available hospital days. We are concerned that this is a illusory additional benefit.

The complex series of trade offs and higher coinsurance or deductibles raises many problems. You have and will continue to hear a litany of suggested improvements to the President's or other legislation, most of which are predicated on the diminution of one benefit (or the acceptance of discriminatory coinsurance, etc.) as a prerequisite for the enhancement of another.

We believe that the needs of patients can best be met by simply treating mental illness, including substance abuse, in the same manner in which any other non-psychiatric medical illness is treated.

In addition to ensuring that any bill adopted by the Congress provides non-discriminatory coverage of treatment for mental illness including substance abuse -- there are a whole host of benefit improvements in the mental health area which are worthy of careful consideration by the Congress, provided that Congress takes care not to "rob Peter to pay Paul" by expanding one specific area of coverage for treatment of mental illness at the expense of another. Suggested improvements the Congress may wish to consider include:

- Special provisions for vulnerable populations such as children and adolescents, the severely mentally ill, and the elderly.

- Elimination of cost sharing for low income and indigent patients, particularly for populations such as children who will inevitably have limited resources.

- Expansion of the outpatient psychotherapy visit limit including elimination of the discriminatory 50% patient cost sharing.

- Specification that treatment of mental illness, including substance abuse, is a mandatory "basic benefit", not an optional "add on".

- Inclusion of any out-of-pocket expenses incurred for treatment of mental illness or substance abuse in any annual catastrophic stop loss established under health care reform.

- Assurance that lifetime limits on coverage do not provide -- intended or otherwise -- a means of dumping patients out of the insured population. This is a particular problem for children and adolescents and their families.

We urge the Congress to consider what is best for the patient as it deliberates on health care reform. We submit that benefit trade-offs, one-day deductibles, and discriminatory 50% patient cost sharing are not in the interests of the patient, and the 50% coinsurance will be a significant barrier to needed care for low and moderate-income persons requiring outpatient treatment. We also believe that Congress should include preservation of patients' rights to contract with their physicians without arbitrary restrictions at no cost to the system. Such contracting could help ensure that the crucial therapeutic relationship between patient and psychiatrist is not interrupted if the patient changes jobs or insurance.

The decision on the most appropriate method of treatment, including the site of service, should be made on the basis of medical necessity, not on available coverage or driven by the financial interests of either the health plan, the utilization review entity, or the individual provider.

We note, for example, that the bewildering system of trade-offs now included in the Health Security Act may create incentives for the plans to steer patients into particular treatment settings based not on medical necessity but rather on the desire of the plan to reduce costs.

The trade-offs as currently envisioned may also create unintended incentives for those providers whose training and scope of practice limits them to outpatient office-based services to encourage patients to trade away their inpatient "bank" of days, thus leaving the patient without potentially necessary care in either the inpatient setting or the intensive non-residential setting.

We strongly urge you to resist the blandishments of some in the mental health community who would have you believe that this complicated system of trade-offs is an "improvement" in the mental health benefit. Rather than spending significant resources trying to track the trade-offs, we would urge you to provide a non-discriminatory, medically necessary benefit.

Finally, of critical importance to the debate over covered health benefits are the assumed costs associated with such benefits. As the Subcommittee may know, there has been much discussion regarding the assumed costs of the mental health benefit within the President's health care reform proposal. There is substantial agreement in the mental health community that the Administration's actuaries have substantially overstated the cost of the mental health and substance abuse provisions because of disagreements about the data on which the estimating is based and the assumptions used to estimate cost. We stand ready to work with the Subcommittee and Congressional budget estimators to ensure that the cost estimates for mental health are accurate and reflect the best available data.

Global Budgets:

Under the President's plan, the national health care budget will be established by the National Health Board. The budget is to be derived from the weighted average premium for the nationally-guaranteed benefits package in regional health alliances. This budget would be translated into a per capita basis (i.e., premium) and would vary regionally. The per capita premium times the number of individuals covered by the Alliance and adjusted for population age, health status and other factors forms the yearly global budget for that Alliance.

If the submitted average premium -- the bids offered by the Accountable Health Plans -- within an Alliance exceeds the premium target, an assessment is imposed on each plan whose bid exceeds the target, and on the providers receiving payment from the plan. Revenues from assessments on plans in excess of the premium target are used to reduce required employer premium contributions. The assessment on the plan is equal to a portion of the percentage amount by which the alliance target is below the bid.

Year-to-year premium increases are limited to the Consumer Price Index (CPI). If however, an Alliance's actual weighted-average premium in a given year exceeds its premium target, then the inflation factor for that Alliance is reduced for the following two years to recover excess spending.

Alliances may utilize various "tools" to meet their premium targets, including: premium negotiation, limiting enrollment in high-cost plans, freezing new enrollment, implementing surcharges on high-cost plans; and setting rates for providers.

While we recognize that equitable cost containment must be an essential part of any serious plan to reform the nation's health care system, it is not clear to us how global budgeting is likely to impact the delivery of services to persons with mental illness, and particularly to the most vulnerable populations of those with mental illness, including children and adolescents (who have no insurance of their own), persons with "severe" mental illness, the poor, and the elderly. **Cost controls should not translate into little or no services for vulnerable populations or else into shifting persons into an underfunded and often non-existent state system of care.**

Graduate Medical Education:

The President's plan -- as would legislation already introduced in the House and Senate -- redirects graduate medical education away from specialties and toward primary care and increased investments in the training of non-physician providers. Within 5 years after the initial phase-in of the reform plan, at least 55 percent of physicians completing their residencies would be required to be in primary care medicine, defined as family medicine, general internal medicine, and general pediatrics, and obstetrics and gynecology.

The new National Council on Graduate Medical Education would be given sweeping powers to determine the number and distribution of every medical specialty, perhaps up to determining even how to distribute those positions across the U.S. depending on regional requirements for such specialties. For example, effective in 1998, the new National Council would be given authority to designate for periods of 3 academic years the number of individuals who may be enrolled in each medical specialty residency or other postgraduate training programs.

By academic year 2002-3, there is a specific requirement that the number of residents who complete eligible primary care programs must be not less than 55% of the total number of residents.

In addition to mandating that at least 55% of residencies are to be in primary care, the Clinton bill would create other incentives for primary care services, including a 10% primary care bonus increase in the Medicare RBRVS practice expense relative values, and a 10% increase in the RBRVS relative work values for office visits. There would also be a 20% bonus payment for primary care services provided in underserved areas.

These efforts will pose severe problems for psychiatric residency and training presently defined, by the National Council on Graduate Medical Education (COGME) as one of a very few medical specialties in need of "protection" under the Health Security Act's graduate medical primary care orientation. Other COGME defined "protected specialties" include general prevention medicine/public health and general surgery.

Not only does COGME define psychiatry as a "protected specialty" (i.e., a specialty that should not be reduced in terms of residency positions), but one that should increase:

> "...year 2000 physician workforce objectives should be to...(4) increase the number of graduating preventive medicine specialists, adult and child psychiatrists, general surgeons...and general internists and family physicians with additional geriatrics training..." Council on Graduate Medical Education, Fourth Report to Congress and the Department of Health and Human Services, Recommendations to Improve Health Care Through Physician Workforce Reform, January 1994.

While psychiatry is not now defined in the statutes as a primary care specialty, psychiatry in general, or psychiatric subspecialties such as child and geriatric, should not only be defined as such because of its "protected" status but also because psychiatrists are the "primary care" physicians for the mentally ill.

Pressures to reform the means by which the Federal Government facilitates the supply of needed physicians should not simply stop at the "primary care" level. Draconian reform measures pose particular problems not just for general shortage specialties such as psychiatry, but for shortage subspecialties such as child and adolescent psychiatry.

With respect to child and adolescent psychiatrists, the current number of fully trained subspecialists is estimated at 6,000. The 1980 Graduate Medical Education National Advisory Council (GMENAC) recommendations set the national requirement for child and adolescent psychiatrists in 1990 at approximately 10,000. About 250 child and adolescent psychiatrists complete training each year with only a slightly smaller number retiring or leaving the field each year, but this will not be sufficient to meet patient care needs. Health care reform should pay special attention to the subspecialty of child and adolescent psychiatry.

We certainly understand the interest of many in Congress in promoting the use of non-physician providers (most typically nurse practitioners and physician assistants) as primary care workforce extenders. While there is a significant role for non-physician mental health providers, Congress should recognize that the services of physician psychiatrists and non-physician mental health providers are not substitutable given the extensive differences in education, training, and clinical practice. We also hope you will recognize the fallacy of recent assertions by some that a family physician plus a non-physician mental health therapist "equals" a psychiatrist. This is both inaccurate and on its face not cost-effective care.

In sum, meat axe proposals to address perceived overspecialization may unintentionally create or exacerbate shortages in needed specialties. We believe that a more appropriate response to health manpower issues would be to expand opportunities to low-cost cognitive services in shortage, particularly emphasizing underserved geographic areas and public sector service (state hospitals, VA, etc.), rather than simply asserting a fixed policy that one-half of all new physicians should be "primary care" (however defined).

Medicare & Medicaid:

As the Subcommittee knows, a significant portion of the cost of paying for the new health care system under the President's draft proposal would come from capping and gradually reducing Medicare and Medicaid spending to the Consumer Price Index, with adjustments for population changes. Medicare and Medicaid spending cuts would be substantial: now estimated at $188 billion over 5 years.

We are deeply concerned about the ability of these programs to sustain reductions of this magnitude without adversely impacting quality of care. Of particular concern to us is the fact that the President's plan does not propose to end existing discrimination against Medicare patients with a diagnosis of mental illness (such as the 50% coinsurance for outpatient mental health services or the 190 day lifetime limit on treatment in psychiatric hospitals).

Since the President's plan would otherwise phase out discriminatory limits on treatment of mental illness in the reformed health system, the distinct possibility is that the Medicare program -- generally among the more comprehensive coverage available today, may actually end up as significantly lesser coverage over time.

Managed Care and Malpractice Issues:

Inevitably, a central element in any health care reform plan -- whether the President's, single payer proposals, and so on, will be the increased use of utilization review and other means of managing the delivery of health care services.

Neither APA nor the Academy oppose managed care per se. Indeed, based on a series of frustrating exchanges with the Administration's actuaries, we believe that we give more credence to the efficacy of quality managed care to control medically inappropriate utilization of mental health services than does the Administration's own cost experts. We do oppose the use of managed care techniques whose sole objective is to reduce costs without regard for the clinical needs of the patient.

We are also concerned that the language on quality assurance in the Health Security Act seems predicated on the assumption that health alliances will be benevolent and disinterested parties whose only objective is to ensure that individual patients receive the health care which they require. There is very little enforcement or penalty language to hold individual alliances accountable for failure to ensure the provision of medically necessary services.

This is a particular problem in the area of medical malpractice. What, for example, is the responsibility of an individual provider whose recommendation for specific treatment has been denied by the plan? The Health Security Act provides only for a limited demonstration project to assess the feasibility of shifting liability from the individual physician or other provider onto the alliance itself. This is woefully insufficient, for while the demonstration project may eventually lead to a solution, providers will be very much at risk in the interim.

We believe that it if the Congress and the Administration determine that it is a national objective to intensify management of health care services which will -- directly or otherwise -- interpose between the physician and patient, national policy must also assume some of the risk for negative patient care outcomes which may result.

We strongly recommend that the Congress adopt rigorous Federal standards to ensure that the reformed health care system ensures the delivery of the appropriate care in the appropriate setting. Quality of care is a critical element in any reformed system, and we welcome working with the Congress for the adoption of criteria to protect patients from abuse.

Confidentiality:

The Health Security Act establishes a Health Information Network, created by the National Health Board, to collect and report a myriad of data. This key element of the Administration's Health Care Reform Proposal is designed to produce an electronic health information network.

Individuals will carry Health Security Cards and have identification numbers. Information gathered on clinical encounters, agreements between health plans and health providers, payment of benefits, and utilization management will be used to evaluate costs, develop policy, and improve the quality of care.

Preserving the confidentiality of the doctor-patient relationship must be the cornerstone upon which this new system is built. In order for psychiatric patients to receive appropriate treatment, they must be able to reveal the most intimate, potentially damaging, information to their physician.

If confidentiality is the fundamental premise of the doctor-patient relationship, then it is the linchpin of the psychiatrist-patient relationship. The welfare of the patient is the first concern of the psychiatrist. From this concern derives the psychiatrist's obligation to protect patients' privacy and maintain the confidentiality of their communications.

The Administration's proposal requires that the National Health Board, two years after enactment, promulgate standards with respect to the privacy of an individual's health information, including safeguards for the security of such information. As outlined in the Health Security Act, the National Health Board has an enormous amount of discretion. Even the principles designed to protect against unauthorized disclosure leave confidentiality at risk if the disclosure is consistent with the Health Security Act and criteria established by the Board.

We urge that as the National Health Board develops privacy standards for the proposed health information system, professional provider organizations be consulted as well as the Federal Agencies, states, alliances, plans, and consumers outlined in the plan.

We strongly recommend that any national health care proposal would recognize that protecting the confidentiality of medical disclosures is especially imperative for those who need and obtain psychiatric treatment. The sensitivity of these records and the therapeutic trust of the psychiatrist -- patient relationship require the highest level of security protection.

Three years after enactment, the National Health Board must submit to the President and Congress federal privacy legislation. While we applaud these efforts to establish a first federal privacy act to protect the individual, we are concerned that until a federal standard is passed, patients must deal with varying standards from state to state or alliance to alliance. We also recognize that establishing security in an electronic system will be a daunting enterprise.

Other Health Care Reform Legislation:

Having addressed the Clinton Health Security Act in detail, I would now like to provide a brief summary of other major health care reform legislation and how such legislation might affect treatment of persons with mental illness.

In general, with respect to impact on psychiatrists and our patients, most health care reform bills would fall into one of two categories:

- Expanded coverage of psychiatric treatment for currently uninsured populations but with significant impact on psychiatric practice, particularly in the area of continuity of care between psychiatrist and patient;

or

- Less direct impact on the psychiatrist/patient relationship, but comparatively less expansion of coverage of treatment of psychiatric illness.

It is difficult in the time allotted to undertake a detailed analysis of the strengths and weaknesses of each individual bill. *Please note that the APA has not endorsed any individual health care reform legislation, and my comments here are offered only as a means of comparing the various House bills.*

H.R. 1200 (Representative McDermott, et al):

Representative McDermott's bill -- cosponsored by most majority members of this Subcommittee -- would establish a "single payer" health system. All citizens would be covered under a uniform national health insurance package financed by savings from administrative simplification and a payroll tax.

Cost controls would be significant, including a national global health care budget with central pricing of health services. Since coverage would be uniform, and since the Federal Government would essentially become the single purchaser and payer of health services, pre-existing condition limitations and exclusionary insurance practices would effectively be eliminated.

With respect to coverage of treatment of mental illness, H.R. 1200 provides a "threshold" mandatory benefit of 15 days of inpatient care and 20 outpatient visits. After the threshold is reached, additional utilization must be reviewed and found to be "medically necessary and appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition."

Covered mental health and substance abuse services specified in the bill include (but are not limited to): crisis intervention; outpatient mental health services; partial hospitalization and day treatment; psychosocial rehabilitation services; psychotropic medications; inpatient services; inpatient and ambulatory detoxification services; long-term residential services for substance abuse; etc.

H.R. 2610 (Representative Stark, et al):

This legislation would provide universal health care coverage through the Medicare system. Benefits -- with some enhancements such as prescription drug coverage and preventive care -- would be modeled on Medicare benefits. Cost controls would be significant, including global health care budgets and use of the Medicare Resource-Based Relative Value Scale (RBRVS) Fee Schedule.

We note that use of the RBRVS payment system is a particular problem for treatment of mental illness in that the Medicare fee schedule substantially undercompensates cognitive services such as psychotherapy which are highly dependent on time as a significant variable. APA has commented at great length to the Health Care Financing Administration and to the Physician Payment Review Commission on the technical problems with the RBRVS, and we would be glad to share our concerns with the Subcommittee under separate cover.

With respect to coverage of treatment of mental illness, H.R. 2610 would use Medicare coverage as a model. While such coverage would be relatively broad, we note that use of Medicare benefits would -- unless otherwise specifically addressed -- entrench inappropriate features of current Medicare law such as the discriminatory 50% patient-borne coinsurance for outpatient psychotherapy, and the 190 day lifetime reserve on inpatient treatment in a freestanding psychiatric hospital.

H.R. 3080 (Representative Michel, et al):

This bill would require business to offer, but not to pay for, a health plan for their employees. Insurance companies would be required to offer to small businesses several types of health care plans (MedAccess standard, catastrophic, and medisave).

Insurance industry exclusionary practices would be limited (i.e., pre-existing condition exclusions would be limited to 6 months and would be waived if an individual changes plans while covered). Cost controls would be moderate, relying largely on insurance market reforms to reduce the cost of coverage.

With respect to coverage of treatment for mental illness, H.R. 3080 does not include a specific benefit requirement for any health services. The National Association of Insurance Commissioners (NAIC) would establish a guideline for benefits, but "no specific procedure or treatment, or classes thereof, is required to be considered" by the NAIC for inclusion.

H.R. 3222 (Representative Cooper, et al):

Representative Cooper's Managed Competition Act is a leading competitor to the President's Health Security Act. The bill guarantees individuals the right to purchase health care coverage, but does not require employers to pay for, or individuals to purchase, such coverage.

The bill would create significant tax disincentives for the purchase of "benefit rich" health care coverage; health care cost controls are predicated on assumptions that individuals would purchase lower cost plans. Purchase of health care coverage by low-income individuals would be subsidized by the Federal Government. Additional cost savings would accrue through the use of health care purchasing cooperatives allowing individual (or business) purchasers leverage by pooling resources. Insurance industry reforms would be imposed.

With respect to coverage of treatment of mental illness, H.R. 3222 does not specify any such coverage, leaving to a national health care standards commission the responsibility for determining coverage of all medical and other health services.

H.R. 3704 (Representative Thomas, et al):

Under this bill, all U.S. residents would be required to obtain health insurance coverage by 2005. Employers would be required to offer, but <u>not</u> to provide, health care coverage to their employees, with subsidies provided by vouchers to low-income individuals and families. Health care cost savings would be achieved largely through limiting employer deductions for -- and employee exclusions of -- health care premiums. Insurance industry reforms would limit pre-existing condition exclusions to 6 months.

With respect to coverage of treatment for mental illness, covered services specifically include "services for severe mental illness" and "substance abuse services" when the service is "medically necessary or appropriate." "Severe mental illness" and "substance abuse services", however, are not specifically defined.

Conclusion:

We know that timely interventions, including the use of psychotropic medications in conjunction with appropriate psychotherapy, can make an enormous difference to persons with mental illness, enabling them to resume a full and productive life. We also know that these treatments are clinically effective and cost effective. And we know that providing coverage for treatment of mental illness would save the nation nearly $100 billion in annual indirect costs incurred from our failure to provide access to care today. We thus believe that coverage of treatment for mental illness should be included in whatever health care reform model the Administration ultimately puts forward.

The APA and the Academy simply ask that psychiatrists and their patients be treated like all other physicians and patients are treated under a reformed health care system.

We, and the medical treatments we provide, whether psychotherapy, psychopharmacology, ECT, or medical management should be subject to the same cost constraints and the same internal reviews as are other physicians and patients. We should be subject to the same outcomes measurements as are imposed on other medical specialties and their patients.

Outcomes and effectiveness studies will show what we have known all along: mental illnesses are <u>real</u>, can be clearly diagnosed, and can be treated effectively. The time for differential treatment, based on stigma rooted in fear and ignorance, is past.

We are heartened by the prospect of reforms to the nation's health care system, and particularly by the prospect that the opportunity for reforming the system as a whole will provide us with an opportunity to end discrimination against persons with mental illness and those who treat them.

We hope members of this Subcommittee and of Congress as a whole will seize the opportunity to redress the long-standing and unjustified discrimination against persons with mental illness which has been a feature of our health care system for far too long. There is simply no justification for diagnosis-driven discrimination in our nation's health care system.

Mr. MILLER. Thank you.

Ms. Buss?

Ms. BUSS. Thank you. Mr. Chairman, as Deputy Director of the Juvenile Law Center in Pennsylvania, I am pleased to appear before you to discuss the importance to children of including good mental health coverage in any health care reform package. In particular, I will focus on the substantial mental health needs of children with the child welfare and juvenile justice systems.

Formerly in Baltimore and now in Pennsylvania I have represented hundreds of children in foster care and institutional placements. The vast majority of children I have represented in substitute care have had emotional and psychological problems.

Children living in substitute care, whether placed through the child welfare, the juvenile justice, special education, or of course by definition the mental health systems have a disproportionate need for mental health treatment. Some studies suggest that approximately 60 percent of children in foster care have moderate to severe mental health problems. Frankly, my experience suggests that the numbers are even higher.

In the child welfare system, children come into the system because of a history of abuse and neglect. A history that leaves emotional scars more often than it leaves physical scars. Moreover, the experience of removal itself for children imposes a tremendous emotional strain.

Children in the juvenile justice system come into the system for different reasons. Often their behavior is a manifestation of some kind of underlying psychological and emotional issue. Again, placement into the system tends to exacerbate the problem.

It is in these children's interests to ensure they receive appropriate, comprehensive and timely mental health services. It is also in society's interests to do so. Children do not outgrow untreated mental illness and emotional problems. The problems, untreated, get worse. Children eventually run out of foster homes who will accept them. They require institutionalization or incarceration, and ultimately they lose their chance to become healthy and productive adults—all this, of course, at considerable State and Federal expense.

To give one example of the cost of foregoing treatment, I turn to the client of a child I represented as a child.

She is now 18 and awaiting the birth of her second child, her first child is now in foster care. As a child herself, she was sexually abused and severely neglected until placed in foster care at the age of 12. She was never provided with effective mental health treatment. It was essentially unavailable to her. And while she is exceptionally intelligent and in fact artistically gifted, she never got effective treatment and her mental illness has been allowed to fester.

Now, at 18, this gifted young lady was just added to the rolls of the SSI program. Essentially the Social Security Administration determined that the lack of treatment to help her deal with her history of abuse and neglect has led her to be unable to hold a job.

In recent years, Congress has greatly enhanced children's opportunities to get effective mental health coverage through its expansion of the Medicaid program for children. This was referred to in earlier testimony, and I want to emphasize its importance.

In 1989, as part of the Omnibus Budget Reconciliation Act of that year, over 1989, Congress expanded the early, periodic treatment program for children, to mandate a provision of all medically necessary services, including mental health services for low-income children, whether or not those services were included in a State's Medicaid plan.

And while the States have been somewhat slow to implement the mandate, they—and Pennsylvania is among them—are beginning to figure out how effective they can be in improving mental health coverage for children as well as physical health, I might add.

OBRA 1989's expansion of the program allows States to develop flexible, individualized and community-based mental health staffs that are directly responsive to a particular child's needs by providing Federal reimbursement for a portion of the State expenditure for all medically necessary services. OBRA 1989 has given States a fiscal incentive to invest in a system that assesses and meets need in each case.

Moreover, EPSDT funding is noncategorical funding. It is not tied to a particular system, whether special education or mental health system, but rather is available for all low-income children based on their medical need. It allows it to be accessed by all systems as appropriate and coordinate delivery of systems.

I think I have time for one quick example of how that system can work and has worked to profoundly affect the quality of care for children and to save the State and Federal Government a considerable amount of money.

I assisted with a child and her family. The child was a four-year-old who engaged in very serious self-injurious behavior, principally head banging, which put her at severe physical risk. Her mother very much wanted to care for her at home but she was really at wit's end. She had other children, a husband, was trying to hold a job as well. The only way the child could remain at home is through elaborate behavior protocols, essentially working through what we think of as easy behavior, whether it is a playing protocol, washing, eating protocol, working through with a child so she could manage her own behavior and not resort to the head banging.

The mother got to the point where she felt she could not handle things anymore and the child welfare system was seriously considering getting involved, removing the child, not because the mother was doing anything wrong but just because the mother was having such a difficult time managing.

Her doctors recommended that the behavior management be introduced in the home—and when I say behavior management I mean something at a fairly sophisticated level to work through the protocols with the mother and to give the mother both respite and assistance in engaging the child in the protocols. Through the EPSDT funding, the behavior management was provided in the home. Needless to say, thousands of dollars were saved, both State and local funds.

Our primary concern is that any health care reform effort must retain the OBRA 1989 mandate that low-income children receive all necessary services including mental health service, and that medical necessity continues to be defined broadly enough to include the wide range of services designed to address the complex and

sensitive treatment needs of children with serious emotional and psychological problems.

Thank you.

[The prepared statement of Ms. Buss follows:]

EMILY BUSS
DEPUTY DIRECTOR

I. Introduction

Mr. Chairman and Members of the Committee. As Deputy Director of the Juvenile Law Center in Pennsylvania, I am pleased to appear before you to discuss the importance to children of including good mental health coverage in any health care reform package. In particular, I will focus on the substantial mental health needs of children in the child welfare and juvenile justice systems.

Juvenile Law Center has been representing Pennsylvania children since 1975. Before I came to the Juvenile Law Center in 1990, I represented hundreds of children in foster care and institutional placements as an attorney for Baltimore's Legal Aid program. The vast majority of children I have represented in Baltimore, and now in Pennsylvania, who are placed outside their homes, have emotional and psychological problems.

Juvenile Law Center has devoted considerable attention to the state and national health care reform movement, and potential effects of such reforms on the quality of health and mental health care provided to children in the child welfare and juvenile justice systems. With other advocates, we have formed the Pennsylvania Children's Health Coalition, made up of consumers, providers, and advocates. This Coalition has the dual purpose of pressing for effective implementation of current federal health mandates for low-income children under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) provisions of the Medicaid law, and of ensuring that health care reform preserves the important gains for children recently established

by these mandates. My particular focus, in Coalition activities and in separate class action litigation, has been on the problems facing children in substitute care--that is, those living in foster homes, group homes, residential treatment facilities, or reform school--in accessing effective treatment.

II. The Special Mental Health Needs of Children in Substitute Care

A. The Heightened Level of Need

Children living in substitute care, whether placed through the Child Welfare, Juvenile Justice, Special Education or, by definition, the Mental Health system, have a disproportionate need for mental health services. Some studies suggest that approximately 60% of children in foster care have moderate to severe mental health problems. Frankly, my experience suggests that the numbers are even higher: In the child welfare system, children come into the system because of a history of abuse and neglect--a history that leaves emotional scars more often than physical scars. Moreover, the experience of removal from one's family, alone, imposes a tremendous emotional and psychological strain on a child. While children in the juvenile justice system come into the system for different reasons, their delinquent behavior often reflects underlying emotional and psychological struggles, and, again, the very placement of children into the juvenile justice system tends to exacerbate their emotional problems.

B. The Value of Treatment

It is in these children's interest to ensure that they receive appropriate, comprehensive, and timely mental health services. It is also in society's interest to do so. Children do not grow out of untreated mental illness and emotional problems. The problems, untreated, get worse--children eventually run out of foster homes who will accept them, require institutionalization or incarceration, and, ultimately, lose their chance to become productive adults--all at considerable state and federal expense.

To give just one example of the cost of foregoing treatment, I turn to a client I represented as a child. (She is now 18 and awaiting the birth of her second child, her first is in foster care.) This client was sexually abused by her step father and severely neglected by her mother until she was placed in foster care at the age of 12. Not surprisingly, the long years of abuse and neglect had taken a profound emotional toll. While she is exceptionally intelligent and artistically talented, she never got effective treatment for her mental illness--which grew throughout her adolescence. Now, at 18, this gifted young lady was just added to the rolls of the SSI program, based on psychological assessments linking her failure to deal effectively with her history of abuse with her inability to hold a job.

III. What Constitutes Good Mental Health Treatment Services for Children in Substitute Care

It goes without saying that good mental health services mean services available in sufficient quantity to ensure prompt access by children who need them. But the "what" of mental health treatment can be even more important than the "when." Mental Health treatment for children--particularly "systematized" children-- must make sense to them, must not feel insulting to them, in order to be effective. For example, in many cases, children are resistant to classic out-patient therapy, the most commonly prescribed form of mental health treatment for these children. They feel spied upon (the therapists want to talk to them about the worst parts of their past) and, once they're set against it, they will prevent such therapy from being effective. As another example, institutional care (classically residential treatment or psychiatric hospitalization), however well-staffed by professionals, can be counter-productive where children perceive placement as evidence that they are unfit for family life. Moreover, for these systems children, mental health services must be designed to address the particular issues that are of primary importance to them, whether that means strengthening shaky familial relationships to allow a child to remain at home, or working on building relationships to prepare for family reunification, or working through the grief of separating from a family.

The "what" of mental health treatment for these children must be responsive to the particular child's needs and circumstances and must, whenever possible, be family and community based to minimize the disruption to the child's physical and emotional world. Moreover, to be effective, these services must be integrated with the other systems in the child's life: the school, the foster family, the probation plan.

IV. The Benefits of the Current System

In 1989, as part of the Omnibus Budget Reconciliation Act of that year, Congress expanded Medicaid for low-income children (the Early and Periodic Screening Diagnosis and Treatment, or EPSDT, program) to mandate provision of all medically necessary services covered by Title XIX, whether or not they are part of a state's Medicaid plan. While the states have been slow to implement this mandate, Pennsylvania, along with other states, have begun to discover that OBRA '89 created a tremendous opportunity to improve mental health services for children.

OBRA '89 allows states to develop flexible, individualized and community-based mental health services that are directly responsive to a child's needs. Because Medicaid provides federal reimbursement for a portion of state expenditures for all medically necessary services, OBRA '89 has given states a fiscal incentive to invest in a system that assesses and meets need in each case, rather than relying exclusively on a short list of

expensive, last-resort treatment options such as psychiatric hospitalization and residential treatment.

Moreover, EPSDT funding is non-categorical, that is, it is not tied with any particular service-delivery system, such as the mental health, child welfare, or special education system, but rather is available to any low-income child, on the basis of medical need. The non-categorical nature of EPSDT funding allows it to be accessed by all systems, as appropriate, and to coordinate delivery of services among systems to children with severe emotional problems, who tend to be involved in many systems at one time. Under OBRA '89, children with emotional problems can be provided with case management assistance to facilitate access to a range of social, medical, and educational services.

Let me give you some examples of the opportunities created by the OBRA '89 expansions of the EPSDT program:

One client of mine, who was abused and neglected for several years before going into foster care, was placed in a locked psychiatric unit when he began to experiment with setting fires. The psychiatric staff of the hospital quickly recommended that he be placed in a less-restrictive residential treatment placement. The problem was that, among the child welfare system's list of residential treatment providers, only one would accept children labeled as "fire setters." While my client and his family were life-long residents of Philadelphia, the single placement initially offered to my client by the child welfare system was in

Arizona--at a cost of $400 per day. What EPSDT funding allowed the Child Welfare system to do for my client, at half the cost of the Arizona placement, was to pay for special support services to monitor the fire-setting risk. This allowed him to be accepted at a Philadelphia facility which had originally turned him down, because of his fire-setting behavior. He was able to maintain his ties with his siblings and mother, and to work with them in family therapy, as he never could have done had he been placed in Arizona. In addition to providing better care for my client, the local placement, modified with EPSDT dollars to meet his specific needs, saved thousands of federal, state, and local dollars.

EPSDT funding can play a similarly important role in ensuring that a child in the juvenile justice system receives effective treatment, and has access to the services most likely to improve his chances of future success in the community. For example, a child who would benefit from placement in a community-based group home may require intensive case management, or a behavioral aide--both of which can be funded through EPDST--to address emotional problems that, if not controlled, might lead to a more secure placement, or, as bad, a pattern of recidivism.

EPSDT funding also offers opportunities to keep children with complex needs out of expensive child serving systems altogether. As an example of this, I point to a four-year-old child I assisted, who engages in serious self-injurious behavior on a regular basis unless her caregivers engage her in continuous and elaborate behavioral protocols. Although her mother wanted

to care for her daughter at home, she was at wits end trying to care for the rest of her family while constantly administering the behavioral protocols. Her frustration and exhaustion led to her placement of the child in an expensive, publicly funded, developmental pediatric hospitalization program. After the hospital worked with the child for a period of weeks, her doctors determined that she was ready for discharge--to the mother if she could handle it, or to the child welfare system for placement in an expensive pediatric nursing facility. The mother could and wanted to care for her child, she just desperately needed help. Again through EPSDT dollars, a behavioral specialist was hired to give this mother some in-home assistance with implementation of the elaborate protocols. The child welfare system never got involved, and the child remained at home.

V. What Any Health Care Reform Should Include

Our primary concerns are that any health care reform effort should retain the OBRA '89 mandate that eligible children receive all medically necessary services, and that medical necessity continues to be defined broadly enough to include the wide range of services designed to address the complex and sensitive treatment needs of children with serious emotional and psychological problems. To be effective, from a treatment and cost perspective, these funds must remain non-categorical. Moreover, this entitlement must remain uncapped in order to be of use in creating flexible, individualized services for children.

It is incoherent to talk about meeting medical and psychological need, if need will be trumped by fiscal ceilings. And it is well-worth repeating that federal and state dollars saved by withholding effective and timely mental health treatment will inevitably be squandered many times over in subsequent institutionalization, unemployability, and repeating cycles of dependency.

In particular, the President's proposal offers much of what we advocate, as it retains the OBRA '89 expanded EPSDT entitlement for a broad range of low-income children. We are concerned, however, at the attempt to cap the entitlement at 1993 spending levels--levels which under-count need significantly, due to states' slow pace in implementing these expansions. In part due to lawsuits brought by our office and other public interest lawyers, Pennsylvania is relatively advanced, compared with most states, in using EPSDT funding to improve the health and mental health services provided to children. Nevertheless, by the end of 1993, Pennsylvania had identified only a fraction of the need for these services. Capping this program of supplemental services at 1993 levels will prevent the program from achieving its goal of meeting the real mental health needs of children most effectively. Moreover, the President's proposed supplemental coverage for special needs children must be expanded to cover all children in the child welfare and juvenile justice systems, both of which groups demonstrate an extraordinary level of need for these additional services.

VI. Conclusion

I want to emphasize our concern that multi-systems children -- children whose lives have brought them into the child welfare system, the juvenile justice system, the special education system, and the mental health system--be provided appropriate and timely mental health treatment that will minimize their disabilities and maximize their opportunity to participate as independent, productive members of society when they reach adulthood.

Mr. MILLER. Thank you very much.

Ms. Wessendorf?

Ms. WESSENDORF. Good morning. I am Suana Wessendorf. I am a crisis interventionist teacher of the for the Elementary Behavioral Disorders Program in Ames, Iowa. I am President of the International Council for Exceptional Children. CEC is an organization of more than 53,000 teachers, professionals, and parents dedicated to improving the education of students with disabilities and those who are gifted.

I request that my complete testimony be included in the record, but in the interest of time I will first outline the major points that are covered in the written document, and then provide the subcommittee with some detail on mental health care for children and its relationship to our schools.

Please note that my comprehensive testimony provides a description of a population of children who are in the most dire need of mental health care services, those with emotional and behavioral disorders. Every child has very individual and unique mental health care needs, and we as professionals have identified a very effective method of addressing these needs.

Implementation of community-based systems of care that coordinate delivery of services between many agencies has proven to be very successful in addressing the mental health needs of children and youth with emotional and behavioral disorders. Schools are an integral player in the systems of care, ensuring that the coordination of services to the child occurs in the least restrictive educational settings.

Again, I refer you to the written testimony, which provides a list of characteristics of an effective system of care, but also references numerous research data that demonstrates the many positive outcomes that result.

To allow you, Mr. Chairman, to capture a more clear picture of a system of care at work, I would like to share a true account of a young boy named Tom. Since the age of three, Tom has been in special education programs throughout the LaGrange area Department of Special Education. He was initially identified as having a delay in social development and later as having multiple learning disabilities.

In fifth grade, Tom became severely depressed and struggled to develop friendships with peers. Although he wanted friends desperately, he could not understand how to approach other children appropriately.

Additionally, certain obsessive compulsive elements of his personality became severe in the form of frightening thoughts he couldn't control. When he revealed thoughts of suicide, his parents and his psychiatrist decided to hospitalize Tom in the child psychiatric unit of a medical center. He was diagnosed as schizophrenic.

For 22 of the next 24 months Tom resided in a variety of institutional settings including an out-of-State placement. His parents describe this experience as disastrous for Tom. Sending him to a residential treatment center had broken the only close attachments Tom had made in his life—those with his family. The prognosis

was dim and the psychiatrists predicted a life of custodial care in a State hospital.

Fortunately, at this time an agency contacted the family about a new project that involved wrapping supports and normalized services around the patient. That contact initiated a long process of multi-agency efforts to bring Tom out of institutional settings and into his home, community, and local school.

Many agencies were involved, including the local school district, the residential placement facility, the National Institute of Mental Health and the Illinois Department of Mental Health. This latter agency's willingness to be funding flexible was instrumental. Tom's State department individual care grant for residential placement was redirected to fund in-house respite care and a behavior management specialist.

Many positives resulted in the involvement in the WRAP project. It was determined that Tom indeed was not schizophrenic but had a pervasive developmental disorder called Asperger syndrome, a high-function, pervasive developmental disorder.

Upon leaving the hospital, Tom entered a partial hospitalization program for a period of four months, during which his academic achievement improved dramatically. By the time Tom had entered a partial hospitalization program, his reading level had slipped to that of an average third grader. However, at the end of his four months, Tom was up to a 7.3 grade reading level.

Tom graduated from the partial hospitalization and went on to a therapeutic day school for the next seven months. As his progress continued, plans were initiated to integrate Tom into his local school. Behavior specialists and Tom's mother met with teachers on three occasions to share case background and methods of behavioral intervention.

On January 19, 1993, Tom walked into his neighborhood school and joined children in the regular classroom for the first time in three years.

Tom's WRAP team, which includes his parents, the school principal, the district social worker, the aide who works with Tom in the classroom, a behavioral specialist and a representative from the therapeutic day school, meet every two to three weeks to discuss progress and coordinate necessary adjustments and modifications. With the assistance of his parents and the classroom aide, Tom is doing well in school, both academically and socially.

Tom described the program best when he wrote of his experiences, "The first day I came to the school I was very worried. I thought I would make a real jerk of myself. I thought I wouldn't know any of the work. I thought the people would treat me like they did last time and call me names.

"Even though I did great and everything was excellent, I studied the Constitution, I watched a movie, I studied for a spelling test, and it was good. Because of my other school, kids would run around the room and swear and talk while people did work, and every once in a while someone would get beat up, but I am glad because in this school that doesn't happen. I get homework, but I like the idea I can do work in peace, without noise, and see and hear bad stuff in class."

Tom's story is not an exception. Community-based systems of care have been proven to have a positive result.

Mr. Chairman, successful stories like Tom's can become a commonplace occurrence if children with emotional and behavioral disorders are provided adequate health care. Because of its dedication to the education of children with special needs, the Council for Exceptional Children is very concerned with the delivery of appropriate health and education services.

We wish to formally acknowledge President Clinton's efforts to make comprehensive health care reform a national priority. For many people with disabilities, both children and adults, there is no question as to the needs for such reform.

There is a health care crisis in this country. As it operates today, the health insurance system fails individuals with disabilities through existing condition exclusions, exorbitant premiums, annual and lifetime limits on services, and a lack of coverage of health-related services such as adequate rehabilitation, assistive technology, and long-term services and supports.

Seventeen million children are uninsured for a part or all of the year, and millions more have private insurance that fails to cover preventive services and other treatment needs of children with disabilities.

Any acceptable health care reform plan must include several basic tenets. One, health care reform must assure universal coverage to all Americans, regardless of employment status, age, health, disability, or ability to pay.

Two, health care reform plans must specify a comprehensive benefit package. People with mental illness and those who advocate on their behalf have grave concerns about passage of any legislation that does not guarantee access to a defined set of benefits.

Three, health care reform must eliminate apparently discriminatory practices of lifetime dollar limits on mental health services, as well as elimination of preexisting condition clauses which are often used to deny coverage to persons with mental illnesses. Only two proposed plans meet these basic requirements. Only two plans make adequate efforts to address the needs of children with mental health needs.

They are the single-payer bills, the American Health Security Act introduced by Representatives McDermott and Conyers and Senator Wellstone, and President Clinton's Health Security Act. While the Council for Exceptional Children and other groups advocating on behalf of children with disabilities see much potential in the President's Health Security Act, there are some limitations to the bill as currently defined.

The Health Security Act approaches mental health coverage in two wide differing formats. Beginning in the year 2001, the administration proposes a comprehensive acute care mental health and substance abuse benefit in which appropriate management replaces prescribed limits on care. The use of a managed system on mental health approach has been shown to produce better outcomes and cost containment than a short-sighted, unmanaged, fee-for-service delivery system.

However, a closer examination of the Health Security Act reveals that the other mental health and substance abuse format provides

a very limited benefit in the interim. Between its enactment and January 1, 2001, the Act relies on a very limited and complicated benefit plan, one that reflects the approach of traditional private health insurers. The interim benefit attempts to limit financial exposure by severely restricting benefits, creating service trade-offs, and requiring extremely high-cost sharing.

Again, my written testimony provides great insight into our concerns with the interim Health Security Act mental health benefit.

Although there exists some substantial concerns about the details of the interim mental health/substance abuse benefit in the Health Security Act, the Council for Exceptional Children wishes to join with other individuals who advocate on behalf of children with disabilities to reinforce the commitment to guaranteed universal health reform.

For all individuals with disabilities, particularly those traditionally underserved, unaddressed populations, such as children and youth with serious emotional and behavioral disorders, true health care reform must involve a guaranteed set of universal benefits that cannot be taken away regardless of disability, preexisting conditions, or ability to pay.

On behalf of the estimated 20 percent of all children with some type of diagnosed mental disorder, one quarter of whom experience severe disabilities that require access to treatment, we call on this subcommittee to pass substantial health care reform that guarantees appropriate delivery of mental health and substance abuse services.

As always, Mr. Chairman, and distinguished members of the subcommittee, the Council for Exceptional Children stands ready to provide every professional resource which it can commend to you as you strive to address comprehensive health care reform.

I appreciate the opportunity to speak before you today and would be pleased to address any questions you may have. Thank you.

[The prepared statement of Ms. Wessendorf follows:]

Ms. Suana Wessendorf
President,
The Council for Exceptional Children

Good morning, Mr. Chairman and distinguished members of the subcommittee. I am Suana Wessendorf, crisis interventionist teacher for the Elementary Behavioral Disorders Program in Ames, Iowa and current President of the international Council for Exceptional Children. CEC is an organization of more than 53,000 teachers, professionals and parents dedicated to improving the education of students with disabilities and those who are gifted.

As the health care reform debate proceeds, one concern repeatedly surfaces- What constitutes fair and appropriate health care coverage? Although I do not have a definition that can address all areas of essential health care coverage, I can provide some insight into what constitutes appropriate health care coverage for children. As an educator, I watch children develop and grow in their own way and at their own pace. Just as each child has his or her own distinct physical and educational needs, every youngster has very specific mental health needs. The amount, type, and duration of mental health service and coverage an individual requires is unique. I am here today to discuss mental health services for children and youth with emotional or behavioral disorders. Children have very different types of mental health needs than do adults. Therefore, the type of children's mental health services should be determined by children's needs, not by those appropriate for adults.

Children and youth with emotional and behavioral disorders (often

identified in schools as having a serious emotional disturbance or SED) can demonstrate a wide variety of problems. Risk factors for this diverse population include history of family mental illness, violence and/or chemical dependency, family poverty and divorce, and parental felony conviction. Children with emotional or behavioral disorders themselves have often been victims of physical and sexual abuse, suicide attempts, drug and alcohol dependency, and are likely to achieve below grade-level in school and to be suspended or expelled frequently. In short, Representatives, these children and youth are very troubled and as a result, their behaviors and actions are often equally troublesome.

Children and youth with emotional or behavioral problems exhibit a wide variety of characteristics:

- an inability to build or maintain appropriate relationships with others- their family members, teachers, and/or peers;
- emotional responses that differ greatly from those of peers, such as a depressed mood, development of physical symptoms, extreme reactions of anger, and low frustration tolerance;
- exhibition of inappropriate behaviors such as abuse directed towards self and towards others, destruction of property, inappropriate social skills, defiance, low motivation, inappropriate sexual behaviors and suicide attempts.

Children with emotional or behavioral disorders may have psychiatric diagnoses such as schizophrenia, affective disorders,

anxiety disorders, and other disorders of conduct.

What Works To Meet Children's Mental Health Needs

While it is important to recognize the risk factors and behavioral characteristics associated with children who have emotional disorders, it is perhaps even more important to explore successful methods of treating and serving these children. Children with emotional or behavioral disorders have a wide array of mental health and education service needs. Unfortunately, there is no one prescription that will "fix" this population as a whole. Every single child must have his/her needs considered individually. Thus, the system of care developed MUST be child-centered. The delivery of services must follow the child; plans of care must be based and implemented on, and only on, the individualized needs of that child and his/her family. Because the mental health and education needs are unique for each individual child, no circumstances exist under which a child should be required to follow a prescribed, one-size-fits-all service delivery plan.

What is the best method for securing this type of individually determined, child-centered system of care? Fortunately, we do have an answer to this question! We do know the most effective way to provide the best possible service delivery system for children and youth with emotional and behavioral disorders. Services for these children must be provided using a

comprehensive system of care philosophy that involves many agencies: those whose business it is to provide mental health services, social services, educational services, health care, vocational services, recreational services and operational services. This system of care philosophy emphasizing comprehensive and individualized services in the least restrictive, most appropriate environment, is the foundation for a decade-old federal initiative, The Child and Adolescent Service System Program (CASSP). CASSP defines a system of care as "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs" of children and adolescents with emotional and behavioral disorders (Stroul & Friedman, 1986).

We have found that our existing agencies do a good job of providing their determined services- educators teach, social service agencies protect children from abuse and place children in foster homes, mental health services provide assessment, counseling and therapy, vocational services find and support jobs. However, children with behavior or emotional disabilities who receive these services do not necessarily benefit from their isolated delivery. When agencies single-mindedly attempt to provide their services separate from each other, the result is a fragmentation that generally results in treatment failures. Use of interagency, multidisciplinary systems of care, with schools serving as an essential and often unifying force, has proven to

be a most effective method to meet the challenge of providing services to children and youth with emotional and behavioral disabilities (Epstein et. al, 1993; Nelson & Pearson, 1991).

Characteristics of Effective Systems of Care

Certain constants exist in those systems of care that truly work for children and youth with emotional and behavioral disorders. The most effective interagency systems of care around the country attribute their success to a number of similar charactersistics including:

o **Commitment to Community-based Services in the Least Restrictive Settings.** Because their problems are so involved, children with emotional and behavioral disabilities are often prime targets for institutionalization and other types of residential placements. Historically, services for this population have been limited to state hospitals, training centers, and out-of-state institutions, requiring the children to leave the community to access services. The preferred system of care involves services available in the child's home community and school. Although we feel strongly that a continuum of placements and service deliveries must be available to this population, it is clear that effective use of an interagency system of care will allow many children and youth to remain in or return earlier to their home communities.

o **Case Management and Team Approach.** A mechanism for central coordination of the individualized service plans is paramount. Case management can ensure that multiple services are delivered in a manner that truly benefits the child. Additionally, the case manager, sometimes called the "care coordinator," coordinates the team of agency representatives that meet regularly to share information, devise, and then implement the child's service plan.
These interagency teams may have one of a variety of names- family services planning teams, staffing teams, and coordinating councils, but the function the teams play is similar. The team members, representing the various agencies, develop a network to facilitate a "wrapping" of services around the child, allowing him or her to get the individualized treatment necessary to address the disability.

o **Family Services.** The families and surrogate families of children with emotional and behavioral disorders must be involved in the planning and delivery of services. Family members need to feel empowered to be full and active participants in the core planning teams. Family services also include provision of direct services, such as parent training, respite care, crisis management, and sibling counseling, all provided in the home and school settings.

o **Early Identification.** A system of care enhances the likelihood

of positive outcomes if it can provide for early identification of children and youth with emotional and behavioral disorders. We should not wait until a child reaches a crisis stage and is at risk of an out-of-community placement before we act. Interagency systems of care must provide for early identification of children's service needs.

o **Flexible Funding.** Interagency agreements steer the systems of care funding. The agreements, however, must retain a great degree of flexibility. To adequately provide for the constantly changing service needs and priorities of each individual child, funding sources must be fluid and quickly responsive. Furthermore, participating agencies must be prepared to commit the necessary resources, as well as be willing to access a variety of alternative, previously untapped, public and private sources.

There are many more components that allow a system of care to maximize its effectiveness. These include access to advocacy services, close and effective home-school coordination and cooperation, and the involvement of positive, caring teachers and other educators. I'd like to share with you a typical case history of a child with an emotional disability. The following is the true account of Tom and his experiences with a system of care, the WRAP program of LaGrange, Illinois (Eber, 1993). I believe you will recognize a number of the characteristics I just

described as being essential to an effective, child-centered, family-focused system of community-and school-based care.

Tom's Story

Since the age of three, Tom has been in special education programs through the La Grange Area Department of Special Education. He was initially identified as having a delay in social development, and later as having multiple learning disabilities. In fifth grade, Tom became severely depressed and struggled to develop friendships with peers. Though he wanted friends desperately, he could not understand how to approach other children appropriately. Additionally, certain obsessive-compulsive elements of his personality became severe in the form of frightening thoughts that he couldn't control. When Tom revealed thoughts of suicide, his parents and psychiatrist decided to hospitalize Tom in a child pyschiatric unit of a medical center. He was diagnosed as schizophrenic.

For twenty-two of the next 24 months, Tom resided in a variety of institutional settings, including an out-of-state placement. His parents describe this experience as disasterous for Tom; sending him to a residental treatment center had broken the only close attachments Tom had made in his life- those with his family. The prognosis was dim; a psychiatrist predicted a life of custodial care in a state hospital.

Fortunately, about this time, a special education consultant from the Area Department of Special Education contacted the family about a new program, Project WRAP, that involved wrapping supports and normalized services around the student and family in natural home, school and community settings. That contact initiated a long process of multi-agency efforts to bring Tom out of institutional settings and into his home, community and local school. Many agencies were involved including the local school district, the residential placement facility, the National Institute of Mental Health and the Illinois Department of Mental Health and Developmental Disabilities. This latter agency's willingness to be funding flexible was instrumental- Tom's state department Individual Care Grant for residential placement was redirected to fund in-home respite care and a behavior management specialist.

Many positives resulted from the involvement in the WRAP project: it was determined that Tom indeed was not schizophrenic, but had a Pervasive Developmental Disorder called Asperger Syndrome, a high-function, pervasive developmental disorder. Upon leaving the hospital, Tom entered a partial hospitalization program for a period of four months, during which his academic achievement improved drastically. By the time Tom, now of seventh-grade age, entered the partial hospitalization program, his reading level had slipped to that of an average third grader. However, at the end of his four months, Tom was up to a 7.3 grade reading level!

Tom "graduated" from the partial hospitalization and went on to a therapeutic day school for the next seven months. As his progress continued, plans were initiated to integrate Tom into his local school. The behavior specialist and Tom's mother met with teachers on three occasions to share case background and methods of behavior intervention. On January 19, 1993, Tom walked into his neighborhood school and joined children in the regular classroom for the first time in three years.

Tom's WRAP team, which includes his parents, the school principal, the district social worker, the aide that works with Tom in the classroom, a representative from the respite program, the behavioral specialist, and a representative from the therapeutic day school, meets every two to three weeks to discuss progress and coordinate necessary adjustments and modifications. With the assistance of his parents and his classroom aide, Tom is doing well in school- both academically (he is maintaining a "B" average) and socially (Tom is now in a setting where he is able to observe and model appropriate social behaviors). Tom described the program best when he wrote of his experiences:

> "The first day I came to this school I was very worried. I thought I'd make a real jerk of myself. I thought I wouldn't know any of the work. I thought the people would treat me like they did last time and call me names. Even

though I did great and everything was excellent, I studied the Constitution, I watched a movie, I studied for a spelling test, and it was good. Because in my other school, kids would run around the room and be obnoxious and would swear and talk while people do work and every once in a while someone would get beat up. But I'm glad because in this school that doesn't happen, even though I hate school period. Another bummer is I get more homework, but I like the idea that I can do work in peace without noise and see and hear bad stuff happen in class."

Tom's story is not an exception- community-based systems of care have consistently proven to have positive results for children and youth with emotional and behavioral disorders. In a review of more than 20 communities emphasizing a system of care approach, service objectives were compared with actual results (Stroul, 1993). The facts speak for themselves:

* The Vermont New Directions program decreased out-of-state placements by 54% over a 17-month period, while simultaneously decreasing the percentage of children experiencing three or more placement changes by 59%.

* The Stark County, Ohio program reduced out-of-county psychiatric placements by 73% over 6 years and reduced utilization of a state hospital by 79% over the latter 3 years.

* The Ventura County, California program data revealed significant gains in school attendance of youth, with students

present 90% of possible school days; the same students made significant achievements in school performance, gaining an average of 1.6 academic years after one year in the program.

* Daily treatment costs for the Alaska Youth Initiative's community-based interventions averaged half of those incurred in out-of-state residential settings (Nelson & Pearson, 1991).

* The Family Mosaic program in California increased parent participation, with over 90% of parents/guardians attending the comprehensive plan of care meeting. This program also avoided an estimated one year cost of over $50,000 by reducing the number of days of detention for the client population.

* By focusing on interventions that maximize natural school resources and supports, the La Grange, Illinois Project WRAP has successfully used individually designed, interagency approaches to maintain students with behavioral and emotional disorders in regular education classroom settings (Eber, 1993).

These examples illustrate the improved outcomes that occur with the implementation of a well-planned system of care. The "best case" scenarios allow you, Mr. Chairman, to see what can happen when agencies work together and coordinate individualized, community-based services for children and youth with serious emotional and behavioral disorders. Systems of care have the potential to prevent severe emotional problems in at-risk populations, reduce out-of-home and out-of-state placements, reduce the length of stay in inpatient and residential settings,

reduce incidences of youth crime and teen suicide, as well as show improved school attendance, performance, and participation in inclusive educational settings. System of care families demonstrate increased parent participation and support, and report increased satisfaction with services. Youngsters receiving services by way of a system of care have reduced contacts with law enforcement and reduced incarceration and recidivism rates for juvenile offenders. It is clear that the children are only the most immediate beneficiaries in system of care programs; when children and youth with mental health needs receive the health and education services they truly need, the outcomes benefit us all.

Children's Mental Health and Health Care Reform

Because of its dedication to the education of children with special needs, the Council for Exceptional Children is very concerned with the delivery of appropriate health and education services. We wish to formally acknowledge President Clinton's efforts to make comprehensive health care reform a national priority. For many people with disabilities, both children and adults, there is no question as to the need for such reform. There is a health care crisis in this country. As it operates today, the health insurance system fails individuals with disabilities through pre-existing condition exclusions, exorbitant premiums, annual and lifetime limits on services and a

lack of coverage of health-related services such as adequate rehabilitation, assistive technology and long-term services and supports. Seventeen million children are uninsured for part or all of the year, and millions more have private insurance that fails to cover preventative services and other treatment needs of children with disabilities.

Any acceptable health care reform plan must include several basic tenets:

1- Health care reform must assure universal coverage to all Americans, regardless of employment status, age, health, disability or ability to pay.

2- Health care reform plans must specify a comprehensive benefit package. People with mental illness and those who advocate on their behalf have grave concerns about passage of any legislation that does not guarantee access to a defined set of benefits.

3- Health care reform must eliminate inherently discriminatory practices of lifetime dollar limits on mental health services, as well as elimination of pre-existing condition clauses, which are often used to deny coverage to persons with mental illnesses.

Only two proposed plans meet these basic requirements; only two plans make adequate efforts to address the needs of children with mental health needs. They are the single-payer bill, The American Health Security Act, introduced by Representatives McDermott and Conyers and Senator Wellstone (H.R. 1200) and

President Clinton's Health Security Act (H.R. 3600).

While the Council for Exceptional Children and other groups advocating on behalf of children with disabilities see much potential in the President's Health Security Act, there are some limitations to the bill as currently defined.

The Health Security Act approaches mental health coverage in two, widely-differing formats. Beginning in year 2001, the Administration proposes a comprehensive acute-care mental health and substance abuse benefit in which appropriate management replaces prescribed limits on care. The use of a managed system of mental health care approach has been shown to produce better outcomes and cost containment than a short-sighted, unmanaged, fee-for-service delivery system. In fact, a 1992 National Institute of Mental Health report found that providing coverage of services required by individuals with severe mental illness will save money. According to the NIMH, the total annual savings in indirect costs and general medical services costs substantially outweigh the treatment costs, resulting in a savings to the nation of $2.2 billion.

A closer examination of the Health Security Act reveals that the other mental health and substance abuse service delivery format provides a very limited mental health benefit in the interim. Between its enactment and January 1, 2001, the Health Security

Act relies on a very limited and complicated benefit plan, one that reflects the approach of traditional private health insurers. The interim benefit attempts to limit financial exposure by severely restricting benefits, creating service "trade-offs" and requiring extremely high cost-sharing.

Three categories of mental health and substance abuse services are covered: intensive non-residential services, outpatient treatment, and inpatient and residential services. Although all three categories of coverage are essential to appropriate service provision to children with emotional and behavioral disorders, in the interest of brevity, I will outline some of the limitations involved with the intensive, non-residential services component. These intensive services are provided in the community and are designed to provide ongoing treatment to individuals with serious disorders. This progressive approach to treatment has great potential for children and youth who require intensive treatment and rehabilitation, in that it promotes community and school-based settings in the child's most natural environment.

Day Limits and Trade-Offs.

The Health Security Act interim benefit provides coverage for a maximum of 120 days annually. However, utilization of the first 60 days involves a trade-off; for every two days of intensive non-residential services used, the number of days covered under the inpatient/residential benefit is reduced by one day. This

can also impact the outpatient coverage, which is often needed to follow-up the intensive non-residential treatment. Psychotherapy and substance abuse counseling visits (considered outpatient benefits), beyond the annual limit of 30 visits, count against the inpatient/residential benefit limits.

The second set of 60 days' coverage, while not involving a trade-off, can only be accessed if a health plan "determines that the individual should receive such treatment". However, the criteria for this determination is not included in the bill.

Copayments.

In the higher cost-sharing plans, the individual is responsible for paying a one-day deductible, in addition to 50% coinsurance for treatment days 61-120. The lower cost-sharing plans involve a $25 copayment per day for the latter treatment days. Perhaps most troubling of all is that regardless of the expenses incurred due to copays and coinsurance, none of these costs count towards the out-of-pocket limits on an individual's annual health expenditures.

It is easy to see that the day limitations, the service category trade-offs, and the high copayments could be a substantial deterrent for families attempting to access mental health services for children with emotional and behavioral disorders. Given that intensive, non-residential systems of care for

children with emotional and behavioral disorders encourage treatment delivery in the least restrictive settings, provide significant cost-reductions, and reduce hospital recividism, CEC encourages a strong reexamination of this interim benefit. Health care reform efforts need to provide incentives to use innovative, child-centered and community-based treatment options.

Although there exists some substantial concerns about the details of the interim mental health/substance abuse benefit in the Health Security Act, the Council for Exceptional Children wishes to join with many other groups and individuals who advocate on behalf of children and youth with disabilities in reinforcing the committment to guaranteed, universal health care reform. For all individuals with disabilities, particularly those traditionally underserved, unaddressed populations, such as children and youth with serious emotional and behavioral disorders, true health care reform must involve a guaranteed set of universal benefits that cannot be taken away regardless of disability, preexisting conditions, or ability to pay. On behalf of the estimated 20% of all children with some type of diagnosable mental disorder, one-quarter of whom experience severe disabilities that require access to treatment, we call on the subcommittee to pass substantial health care reform that guarantees appropriate delivery of mental health and substance abuse services.

As always, Mr. Chairman and distinguished members of the

subcommittee, the Council for Exceptional Children stands ready to provide every professional resource which it can command to you as you strive to address comprehesive health care reform. I appreciate the opportunity to speak before you today and will be pleased to address any questions you may have.

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Mr. MILLER. Thank you.

Mr. Feltman?

Mr. FELTMAN. Good morning. I am the Mental Health Director in Ventura County, a county that serves a population of 700,000 people in Southern California. It is a pleasure to be here and to see you again, Congressman Miller.

Your friends and supporters in California very much appreciate your leadership and continuing advocacy in this area that we wish was more popular with more elected officials. And as a New Jersey native and as a Rutgers alumni, I have to say it is a special treat to have the opportunity to meet Mrs. Roukema today. So I appreciate that very much.

For almost 15 years I have been involved in programs designed to demonstrate to public sector decisionmakers the benefit and cost of children's mental health services when they were delivered as part of a community-based system of care. These decisionmakers include State and local elected leaders, State agency managers, and analysts and accountants from control agencies such as the legislative analysts office and the department of finance.

In 1985, the California legislature designated Ventura County as a demonstration county to develop a system of care for seriously emotionally disturbed high-risk children that would increase benefits to the child and reduce overall public sector costs.

We were asked to determine if mental health treatment and case management for high-risk children, provided in collaboration with special education, juvenile justice and child protective services and others in the community, would enable these children to remain with their families, succeed in school, avoid delinquent behavior, and thereby offer alternatives to expensive hospitalization, residential care, and jail.

Within a year after we started and up to the present, we have met or exceeded the performance requirements that have been established in our contract with the State of California. The validity and accuracy of the outcome data have passed many external reviews over the years.

The system of care reform has gained strong and enthusiastic support from two governors, their administrations, and bipartisan support from both chambers of the California legislature. In fact, additional legislation was passed in 1989 and revised in 1992 to expand this reform to all 58 counties.

The cost controllers in State government have been especially strong and powerful allies. At the local level, elected members of our board of supervisors are unanimous and enthusiastic about the demonstrated outcomes in the value of mental health services for children.

They also understand that inescapable and very high per-child costs for hospital care, out-of-home placements, and delinquent recidivism would rise dramatically if mental health services were withdrawn from these children and families.

Our experience and outcomes have a direct relation to the discussion about the inclusion of child mental health services in a health reform package. The financial pressure to restrict benefits has barely begun, and mental health services seem to have already been eliminated, or delayed.

Apparently some believe the health care package without children's health care benefits will cost less. Our experience and evidence is clear that targeted mental health services, organized into a community-based system of care, will in fact reduce both short-term and long-term public sector costs.

We have learned that human services are interdependent and that mental health services will improve outcomes and reduce costs in special education, juvenile justice, social services, as well as reduce the need and cost within the mental health system for local psychiatric and State mental hospitals.

Let's consider some specific groups of high-risk children. Seriously emotionally disturbed special education pupils will not disappear because mental health treatment is unavailable. Across the country these children fail to learn, disrupt the classroom and increasingly are being placed in residential facilities costing the taxpayers $40,000 to $160,000 per year per student.

As an alternative in Ventura, we invest in collaborative day treatment programs with additional in-home services that enable children to stay at home and in school and cost far less than out-of-home placements.

Mentally disordered juvenile offenders do not disappear because mental health treatment is available. They increasingly get sent to residential group homes, funded through Title IV–E, costing $40,000 to $100,000 per year per child, away from their community for years or until they run away.

In California alone, 9,000 of these troubled adolescents have been placed in these facilities by juvenile courts. With no appropriate mental health treatment, they frequently reoffend, with often more serious crimes, and spend more time in expensive local detention facilities or State-operated youth authority facilities.

The cost of recidivism and longer periods of incarceration, which is about $30,000 to $40,000 per year, is increasing across the country for untreated juvenile offenders with serious emotional problems. Mental health services can change the outcome for these youngsters.

In Ventura, the probation department, county schools, and mental health department collaborate as a team on a single plan to offer alternatives for the judge and youngster that are less expensive, achieve better outcomes, meeting fewer arrests and days of reincarceration, and maximize family participation and responsibility.

Finally, seriously emotionally disturbed, abused children served by the social services departments also do not disappear because mental health treatment is not available. Without treatment, these children are less likely to return home and often don't succeed in local foster homes.

So they are placed in increasing numbers across the country into group homes far from the community and their family at public expense under Title IV–E, ranging from $35,000 to $160,000 per year per child. California maintains a population of 6,000 children in group homes at an annual cost of $2 million in Title IV–E costs, not including costs for residential public schools, Medicaid and case management.

I want to emphasize that we avoid significant out-of-home placement costs through community-based systems of care because I believe the final decisions about health reform benefits will be made primarily on the basis of perceived cost.

As I have described, the total 1993–394 Title IV–E costs for these 15,000 court wards and dependents placed in group homes in California will exceed $500 million. A table attached to my testimony compares the rate of Title IV–E spending by county in California and shows Ventura spends 42.8 percent of the State average, ranking as the second lowest among the 58 counties.

If children's mental health treatment were available in all California counties and provided in accordance with system of care requirements, California could reduce its Title IV–E expenditures more than $300 million per year, and these mental health services would enable these children to remain with their family, stay in school and learn and commit less crime.

To use an expression originated by Robert Kennedy, we can bend history for these youngsters and change them into better functioning adults.

Our experience demonstrated that at least 40 percent of these children in out-of-home placements could be maintained successfully in the community if targeted mental health services were available as part of a performance-based system of care.

This savings alone could more than pay for the cost of a children's mental health benefit within the health reform package in California. Performance contracts between State health alliances and local health systems of care could place priorities and performance requirements into contracts.

In conclusion, our evidence indicates that the availability of targeted mental health services for children organized into a system of care in a community has a significant correlation with improved client outcomes and reduced public cost for special education, juvenile justice, child protective services as well as health and mental health.

I have also attached a one-page description of the Ventura planning model for your review. Much more information, including detailed performance data about this system of care, is available on your request from me.

Thank you very much for the chance to come and talk to you about what I believe is a very important issue.

[The prepared statement of Mr. Feltman follows:]

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VCMH Ventura County Mental Health
A Division of the Ventura County Health Care Agency
Randall Feltman, L.C.S.W.
Director

Committee on Education and Labor
U.S. House of Representatives
Subcommittee on Labor-Management Relations
Hearing on Health Care Reform

Testimony : Randall Feltman, Director
Ventura County Mental Health Department
February 22, 1994

For almost fifteen years I have been involved in programs designed to demonstrate to public sector decision makers the benefit and cost of children's mental health services when they are delivered as part of a community-based System of Care. These decision makers include state and local elected leaders, state agency directors and managers from the Departments of Health, Mental Health, and Social Services, and analysts and accountants from control agencies such as the Legislative Analyst's Office and the Department of Finance.

In 1985 the California Legislature designated Ventura County as the Demonstration County to develop a system of care for seriously emotionally disturbed, high risk children that would increase benefits to the child and reduce overall public sector costs for these children. This was a "new way of doing business" that required a new way of planning. Essentially, we were asked to determine if mental health treatment and case management for high risk children provided in collaboration with Education, Juvenile Justice, Child Protective Services, and others would enable these children to remain with their families, succeed in school, avoid delinquent behavior and, thereby offer alternatives to expensive hospitalization, residential placement, and jail. It quickly became clear that a system of care approach would work. Within a year after we started and up to the present we have met and exceeded the child benefit and financial outcomes specified in our performance contracts with the State.

The validity and accuracy of the outcome data have passed external reviews and evaluations. The System of Care reforms have gained strong and enthusiastic support from

two Governors, their administrations, and bipartisan support in both chambers of the California Legislature. In fact, additional legislation was passed 1989 and revised in 1992 to expand this reform to all 58 counties. Eleven new counties have been funded under the terms of reform legislation in spite of a long and severe recession restricting State Government's resources for human service investment. Surprisingly, the cost controllers in State Government have actually been strong supporters and powerful allies. At the local level, elected members of our Board of Supervisors are unanimous and enthusiastic about the demonstrated outcomes and value of mental health services for children. They clearly understand that inescapable and very high per-child costs for hospital care, out-of-home placements, and delinquent recidivism would rise dramatically if mental health services were withdrawn from these children and families.

Our experience and outcomes have a direct relevance to current discussions about the inclusion of child mental health services in a Health Reform package. The financial pressure to restrict benefits has barely begun and mental health services seem to have already been limited , delayed, or eliminated. Apparently, some believe a health care package without children's mental health benefits will cost less. Our experience and evidence is clear that targeted mental health services organized into a community based System of Care will, in fact, reduce both short-term and long-term public sector costs. We have learned that human services are interdependent and that mental health services will improve outcomes and reduce costs across systems in Special Education, Juvenile Justice, Social Services, as well as reduce the need and costs within the mental health system for local psychiatric and state mental hospitals.

Let's consider the high risk children. Seriously emotionally disturbed, special education pupils will not disappear because mental health treatment is unavailable. Across the country, these children fail to learn, disrupt the classroom and, increasingly, are being placed in residential facilities costing the taxpayers $40,000 to $160,000 per year, per student. As an alternative, in Ventura we operate collaborative school-based mental health day treatment programs with additional in-home services that enable children to stay at home and in school and cost far less than out-of-home placements.

Mentally disordered juvenile offenders do not disappear because mental health treatment is not available. They increasingly get sent to residential "Group Homes", funded through Title IV-E, costing $40,000 to $100,000 per year, per child, away from their family and community for years or until they run away. In California alone, about 9,000 of these troubled adolescents are placed in these facilities. With no appropriate mental health treatment they frequently re-offend with often more serious crimes and spend more time in

expensive local detention facilities or state operated Youth Authority facilities. The cost of recidivism and longer periods of incarceration ($30,000 to $40,000 per year) is increasing across the country for untreated juvenile offenders with serious emotional problems. Experienced public agency staff in the community can identify many of tomorrow's criminals today. Mental health services can change the outcome for these youngsters. In Ventura, the Probation Department, County Schools, and the Mental Health Department collaborate as a team on a single plan to offer alternatives for the Judge and youngster that are less expensive, achieve better outcomes (fewer rearrests and days of reincarceration), and maximize family participation and responsibility.

Seriously emotionally disturbed abused children served by Social Service Departments also do not disappear because mental health treatment is not available. Without treatment, these children are less likely to return home and often don't succeed in local foster homes. So they are also placed in increasing numbers across the country into "Group Homes" far from their community and family at public expense, under Title IV-E, ranging from $35,000 to $160,000 per year, per child. California maintains a population of about 6,000 abused children in "Group Homes" at an annual cost exceeding $200 million dollars of IV-E cost not including additional taxpayer costs for residential non-public school, Medicaid, and case management staff costs to visit and monitor these children monthly or quarterly. Additionally, there are no requirements for the 24 hour care facilities to measure or report outcomes or assess cost benefit.

I want to emphasize that we avoid significant out-of-home placement costs through community based Systems of Care for children with serious emotional and behavioral problems because I believe that final decisions about Health Reform benefits will be made on the basis of relative cost benefit.

As described above, the total 1993-94 Title IV-E cost for these 15,000 Courts Wards and Court Dependents placed in "Group Homes" in California will exceed 500 million dollars. The attached table compares the rate of Title IV-E spending by counties in California and shows Ventura spends only 42.8% of the State Average, ranking as the second lowest in the State. If children's mental health treatment were available in all California counties and provided in accordance with System of Care requirements California could reduce it's Title IV-E expenditures more than 300 million dollars per year. And these mental health services would enable these children to remain with their family, stay in school and learn, and commit less crime. To use an expression originated by Robert Kennedy, we can "bend history" for these youngsters and change them into better functioning adults.

Our experience indicates 40% or more of these children could be maintained successfully in the community if targeted mental health services were available as part of a performance based System of Care. This savings alone could more than pay for the cost of a children's mental health benefit within the health reform package in California. Performance contracts between a State Health Alliances and local health Systems of Care could place these priorities and performance objectives in writing.

In conclusion, our evidence indicates that the availability of targeted mental health services for children organized into a System of Care in the community has a direct and significant correlation with improved client outcomes and reduced public costs of Special Education, Juvenile Justice, and Child Protective Services, as well as Health Care. Attachments for your review include a one page description of the Ventura Planning Model to implement Systems of Care and the table referred to above comparing the numbers of placements and the rate of Title IV-E expenditure in all 58 counties in California. Much more information including detailed performance data about this System of Care Model is available on your request from:

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Thank-you for this chance to offer my testimony to you on this important aspect of health reform.

The California System of Care Planning Model

February, 1994

The California System of Care Model has five essential requirements. Experience during the past eight years has demonstrated these requirements to be the core building blocks for reform and a successful community-based system of care that provides the greatest benefit at the lowest cost for the available public funds.

1. Clearly and specifically define the targeted populations - Acknowledge limits. Show who will receive service.
2. Specify observable and measurable outcome goals - Establish the purpose of the service.
3. Identify and develop partnerships - Leverage and maximize existing expertise and resources. Don't just "add-on".
4. Develop goal-directed, client-centered, and family focused services - Show how the outcomes will be achieved.
5. Measure outcomes (client and cost avoidance) over time and across agencies - Demonstrate accountability.

The California System of Care Planning Model utilizes these simple and common sense planning steps as a foundation to understand the problem or need, provide focus and direction toward a solution, develop an action plan, and demonstrate accountability. These requirements applied to children with serious emotional and behavioral problems are as follows:

1. **TARGET POPULATION -** The minimum client population is specified for the public sector. Treatment is not given on a "first come, first served" basis. Instead, priority is assigned to the highest risk, most expensive, multi-problem children separated or at imminent risk of separation from their families. These children include mentally disordered juvenile offenders, mentally disordered victims of child abuse who are court dependents, seriously emotionally disturbed special education students, and others with impairments that place them at risk of hospitalization or out-of-home placement. Heavy public sector legal responsibility and financial liability already exists for these children. When removed from their families, government assumes a difficult, expensive, and life shaping responsibility. These children's experience puts them at the highest risk of remaining public charges for their entire lives.

2. **CLEAR OUTCOME GOALS** - Family preservation, school attendance and academic achievement, and preventing delinquent behavior are the desired outcomes for these seriously emotionally disturbed children. It is in the child's and the public's best interest to maximize parental responsibility and keep a high risk child in his or her own home, or local foster home if protection is needed. It is also in everyone's interest to keep a child in school and out of jail. When separation is necessary the goal is to enable a child to return to the family as soon as appropriate. Preserving families, staying in school and learning, and not committing crime are clear, measurable outcomes.

3. **INTERAGENCY PARTNERSHIPS** - Multi-problem children require interagency solutions. Mental Health services are delivered in partnership through a human service network with Schools, Child Protective Services, Juvenile Justice, and other public and private agencies and resources. Coordinating or integrating agency expertise and resources to treat the full range of problems that put the child at risk is more effective. Collaboration meets the service needs of the whole child, rather than parallel efforts by separate agencies to treat parts of a child's problem. Blending funds across agencies provides leverage for single agency sources of funds and increases program options. Written interagency agreements define roles and provide clear expectations for collaborating agencies. Private sector involvement and participation is solicited, coordinated and focused on high risk children and the desired outcomes.

4. **SERVICES AND STANDARDS** - All services are designed as a continuum of alternatives to more restrictive, intrusive, and expensive "deep end" out-of-home placement and hospitalization. Treatment services are conceptualized as "family maintenance" or "family reunification". Interagency screening and case management is added for all children in the system who are at risk of a placement more restrictive than a foster home. Clear clinical standards are defined. Cultural differences are acknowledged as important issues related to effectiveness. Equitable program access, culturally sensitive program design, and successful outcomes for all cultural groups are important system issues. A continuum of services reduces cost when children are served effectively in less expensive levels of care.. A service continuum fills the gap between once a week office visits and hospital admission.

5. **SYSTEM MONITORING** - Outcomes and public costs for all members of the target population are measured across agencies and over time. Measures include the number of residential placements for children from the county, attendance and academic progress in public school for children receiving treatment, the rate recidivism among mentally disordered juvenile offenders, and the number of local and state hospitalizations. Public costs for hospital care, Title IV-E funded "Group Homes", residential non-public schools, and days of reincarceration are also measured. Outcome and cost data provide a constant feedback loop to inform managers of progress or deficiencies.

Taken together these simple, common sense characteristics and planning components can provide the essential framework to develop a community-based, comprehensive, interagency System of Care for seriously emotionally disturbed children.

Fiscal Year 1992 AFDC-FC Group Home Cost Per 100K Total Population

County	7/1/92 Popl Estm	Total Ann Payments	Month Paym Per 100K Popl	Total Ann Cost	Month Cost Per 100K Popl
Sierra	3,300	103	260	$204,194	$515,641
Siskiyou	44,900	1,367	254	$2,572,718	$477,490
Lassen	28,600	873	254	$1,449,276	$422,283
Glenn	26,100	530	169	$1,255,428	$400,839
Yuba	61,900	1,329	179	$2,702,086	$363,770
Alpine	1,200	13	90	$48,014	$333,431
Modoc	10,200	134	109	$404,001	$330,066
San Francisco	744,500	7,775	87	$25,274,358	$282,901
Plumas	20,900	372	148	$700,606	$279,348
Inyo	18,300	230	105	$506,479	$230,637
Sacramento	1,111,900	11,741	88	$28,352,146	$212,490
San Benito	39,300	425	90	$942,996	$199,957
Tulare	335,200	2,420	60	$7,948,951	$197,617
Merced	189,900	1,664	73	$4,373,204	$191,908
Solano	366,800	2,739	62	$8,304,192	$188,663
Shasta	159,600	1,603	84	$3,553,006	$185,516
Tehama	53,100	557	87	$1,173,798	$184,212
Contra Costa	846,400	5,950	59	$18,268,884	$179,869
San Joaquin	509,600	4,336	71	$10,666,216	$174,421
Butte	194,600	1,723	74	$4,029,741	$172,565
Los Angeles	9,128,200	65,739	60	$188,813,057	$172,372
Mendocino	83,400	607	61	$1,718,383	$171,701
Placer	191,100	1,727	75	$3,932,086	$171,467
Napa	115,800	868	62	$2,301,356	$165,613
Del Norte	27,300	260	79	$542,186	$165,502
Colusa	17,300	150	72	$335,085	$161,409
San Luis Obispo	226,600	1,716	63	$4,125,291	$151,710
Humboldt	125,400	803	53	$2,069,457	$137,524
Nevada	84,800	544	53	$1,328,214	$130,524
Trinity	13,400	122	76	$208,737	$129,812
El Dorado	138,900	1,010	61	$2,127,935	$127,666
Calaveras	36,300	276	63	$554,711	$127,344
Stanislaus	401,100	2,721	57	$6,050,884	$125,714
Mono	9,900	50	42	$145,797	$122,725
Mariposa	15,800	84	44	$219,570	$115,807
San Bernardino	1,538,700	7,691	42	$20,854,674	$112,945
Kings	108,900	450	34	$1,418,920	$108,580
Yolo	149,000	739	41	$1,857,648	$103,895
Santa Clara	1,550,900	6,353	34	$18,963,634	$101,896
Marin	239,300	904	31	$2,843,066	$99,006
Fresno	723,000	3,550	41	$8,584,200	$98,942
Tuolumne	51,800	230	37	$607,051	$97,659
Orange	2,531,200	10,214	34	$29,595,697	$97,436
Sonoma	411,700	1,621	33	$4,715,437	$95,446
San Diego	2,632,000	8,351	26	$29,511,167	$93,437
Alameda	1,329,700	5,726	36	$14,694,286	$92,090
Lake	55,000	237	36	$598,973	$90,753
RIVERSIDE	**1,307,000**	**4,292**	**27**	**$13,008,813**	**$82,943**
Kern	595,200	2,408	34	$5,756,493	$80,596
SANTA CRUZ	**236,200**	**795**	**28**	**$2,276,456**	**$80,315**
SAN MATEO	**676,100**	**1,540**	**19**	**$6,209,148**	**$76,531**
Santa Barbara	386,400	1,104	24	$3,523,820	$75,997
Madera	100,400	455	38	$893,958	$74,200
Amador	32,400	139	36	$285,879	$73,529
Monterey	373,500	1,318	29	$3,160,275	$70,510
Sutter	70,100	186	22	$561,713	$66,775
VENTURA	**695,600**	**1,525**	**18**	**$4,888,964**	**$58,570**
Imperial	124,300	206	14	$559,639	$37,519
STATE TOTAL	**31,300,000**	**182,595**	**49**	**$513,452,744**	**$136,702**
377 Counties Total	**2,914,900**	**8,152**	**23**	**$26,383,381**	**$75,427**
377 Counties %	**9.3%**	**4.5%**	**47.9%**	**5.1%**	**55.2%**
Ventura %	**2.2%**	**0.8%**	**37.6%**	**1.0%**	**42.8%**

Mr. MILLER. Thank you very much to all of you for your testimony. In the area of health care reform, we are not going to get into a debate today; we are just going to have a discussion.

There seems to be sort of an accepted view that somewhere out there, within the total health care system, these dollars are being spent anyway, for the uninsured and for the insured; the people find care, whether it is the care of last resort, whether it is an emergency room, however they do it, and somewhere in the universe those dollars are being spent and health care reform is about the reorganization of those existing dollars that we spend in this country. And so you can quickly talk about the uninsured, the insured, in one quick breath here, on the theory that we are doing it anyway, we are just not doing it as well as it can be done.

When we get into the mental health field, it seems to me that that assumption is not being made, and it seems we don't have a unified system where we can say people are either being taken care of or they are not, but somehow they can enter that system, because they slop over onto these other systems. They show up in juvenile justice, they show up in the criminal justice system.

So when we start to reorganize that, all of a sudden these concerns about cost that we have sort of accepted within the physical illness area are not brought forth in mental health in terms of the reorganization of those dollars.

We are not getting credit for the Title IV–E dollars that we are spending today if we provided up-front services, and we were able to prevent those placements. Where we say to somebody, If we provide you a health insurance plan, we are going to take credit for getting you preventive services so you don't go to the emergency room to take care of your pneumonia; we are going to get when you have the flu or whatever it is.

And it seems to me that that is reflected in the President's plan, because they have this kind of crazy little internal—what they view as cost containment going on, and these trade-offs with inpatient days and partial payments.

I must say, Dr. Robinowitz, you have done about as good a job as you can explaining this, and it is frightening when you are reading it, but I can imagine a consumer trying to read this, you can't imagine Mrs. Davidson wanting to read this.

I assume we don't accept that we can create a unified system. Yet, Ventura County and other places are essentially working on those models.

Am I making myself clear? I am just yapping up here.

So the fact is, you say California would save $300 million if we presented mental health for juveniles in the fashion in which Ventura County is, but no one is going to give you credit for offsetting the cost of providing that service within the President's plan or any other plan, as I read it. Somehow we have got to square up the bookkeeping here in terms of the real benefits of providing this as a benefit within the health care plan.

But the model is different. How do we do that? Otherwise, I am afraid we are sticking with these old models of 30 inpatient days and 60 inpatient days and that is not how you provide a broad base of treatment to people based upon what their needs are on at a given time.

That doesn't really allow, as you said in your statement, you know, the performance contracts between State health alliances and local health systems of care. That is not allowed under the President's plan, really, because you are restricted to how you would use those dollars and what you would get—what would be subject to copayments or who would be subject to limitations.

So his plan, we will all give him credit for what he has done, but his plan doesn't really address that array of services that are necessary for families with mental illness.

Let the record show they are all agreeing with the Chairman.

Mr. FELTMAN. That is very true. The book that was very popular for a while, it seems to be a fashion, and is going away, is Reinventing Government. Health care reform offers us an opportunity to fund outcomes instead of methods. And it would be wonderful if people like me in a community were given the opportunity through health reform to accomplish goals that elected leaders said were important to you.

If you want children to stay at home and in school and out of jail, then pay us with as much flexibility as you can, and the resources that are available to achieve those outcomes and measure our performance.

Let us work with Mrs. Davidson and schools and other local providers to achieve outcomes instead of focusing on the services in the first inning and the ninth inning, like we are going to fund these services and not fund these other services.

Because I frankly think the method has changed, just as technology has changed in every other field. If we lock ourselves into paying for specific technologies, we make a fatal mistake.

Mr. MILLER. Isn't that in fact what we did with Title IV–E?

Mr. FELTMAN. Almost all of the streams of funding are very inflexible and basically pay specific providers to do specific things.

Mr. MILLER. When you say—when the Ventura plan saves $40, there is really no benefit of doing that.

Mr. FELTMAN. Well, in California now the counties pay 60 percent of the non-Federal cost, and even though that represents only about 35 percent of the total cost, there is a local benefit, and so local policymakers have begun to pay attention to that.

But it is very true that we get no benefit in Ventura County of spending 42 percent of the State average from the Federal Government. The Federal Government takes that money away from us and spends it on something elsewhere, they do put more kids in that eligible funding stream.

There is no incentive for us to control Federal costs in that legislation at all. We get paid on an entitlement basis as much as we put in there but nothing in the community if we develop alternative services.

Mr. MILLER. You don't get to recycle Title IV–E dollars into services?

Mr. FELTMAN. It would be wonderful if that kind of an option was there. One of the things we all have in common is we are community-based providers and advocates, and Mrs. Davidson is talking about what is available to her in her home community. And that is where the money doesn't exist. The moneys that are provided by the Federal Government largely are paying for kids to

leave their community because of inadequate resources in their community.

Mr. MILLER. Not only that, but in a number of the placements that you cite, in the in-State and out-of-State placements, there is limited evidence that those services are being provided in those placements. It is not like you send them to a group home and they get a whole array of services. What they get is shelter and control. Hopefully they get shelter.

Ms. BUSS. Typically what you are doing is trying to work on whatever issues are preventing them from managing successfully in their family. You send them 2,000 miles away out of their community, and whatever they learn is not going to be directly transferred to what they really need to learn, which is how to function in their community and their families.

I want to say one thing about my understanding of the Clinton proposal that to some extent is in extra layer on the mental health analysis, which is for low-income children, my understanding is that essentially what is covered by the expanded Medicaid entitlement is preserved. The concern we have is it is preserved with a cap, at 1993 spending levels, and the concern there is that States are just learning to spend the money effectively, to save money by spending money, to use the money to develop community-based resources. And 1993 is not a year that in any way reflects the needs that these children have.

Mr. MILLER. If you took those dollars and you combined them with turning Title IV–E into a service program or at least give the counties the option of, you know, trying to prevent placement services with Title IV–E dollars, these start to have a fairly well-financed, relatively well-financed program that is very broadly based in terms of the array of services that would then be eligible for purchase.

Ms. BUSS. As you know, Title IV–E is capped. When kids go into the system the money is not capped at all and it can be spent, thousands and thousands, on children. When you focus on community-based, family-based resources, all the proposals on the table are capped proposals. They are not going to work if they can't be flexible and uncapped.

Mr. MILLER. Let me just—there appears to be no disagreement among you about the fact that these have got to be community-based services that—I keep saying broadly based, but you have a range from intensive therapy to after-school care to whatever that basket of services that that family, that individual needs, that has got to be included under the definition of services for mental health.

But that kind of goes against the health care model, as it is defined in these various pieces of legislation. I think in the single payer system we sort of assume that, in that bill. But the President, to his credit, has laid it out more definitively than anyone else, but what you see is it is almost contradictory to providing those kinds of services.

Dr. Robinowitz, in your paper—and all of you should read her testimony—these people are going to be treated completely differently than people with physical illnesses in terms of figuring

out, this is subject to 50 percent coinsurance, does this deal with the total loss for the year, does this apply or it doesn't apply.

It looks like what everybody says they don't want to have happen in this system in terms of the old insurance policy mentality where we can't get through it because we can't read enough fine print, yet in the mental health benefits that is exactly what the President's plan appears to have achieved.

Dr. ROBINOWITZ. And you see this with children with physical illnesses as well. A child with diabetes, they don't just need so many office visits, so many days in the hospital—it is silly to talk about it. Yet, when we have mental disorders that are as equally complex as diabetes and just as chronic, you need an intervention that will deal with where the child in the family is at that particular time.

That is what should determine the necessity of care rather than the number of days or kinds of treatment or episodes of treatment which we don't do for anything else.

Mr. MILLER. What is driving this approach? What is driving this? Is this interest group, or is this—is this the way you score it? Are they leading themselves to believe they are keeping down the cost?

Dr. ROBINOWITZ. I think there is probably a financial incentive, financial issues that are driving it. The other is history. Historically people have talked about numbers of days, number of visits. Even the Federal Government has a discriminatory copay if you look at Medicare.

Mr. MILLER. I understand that. That is essentially a failed model. We know that mental illness doesn't last for only 30 days or only if you are in a hospital setting. All of those criteria don't work.

Dr. ROBINOWITZ. Right. And there is a fear that there is a bottomless pit, we don't hear from any other kind of coverage, even acute or chronic care coverage. You have to look at not just the medical system or even the social services system, but how it relates with other systems. We have, for example, more people with psychiatric disorders who are in the jails and prison than there are in hospitals. That always—every time I say it, I stop and think, that can't be right, but it is.

Mrs. ROUKEMA. Or they are out on the streets as homeless.

Dr. ROBINOWITZ. Who are not covered in any system right now.

Mr. MILLER. If we had a well-designed system, we would not get credit for keeping those people out of jail cells or off the streets or what have you, where in the traditional medical system they are going to take credit for offering preventive care. They are going to say they are going to get a savings from that.

Dr. ROBINOWITZ. Exactly.

Mr. MILLER. In the mental health benefit it doesn't say that.

Dr. ROBINOWITZ. It also doesn't deal with what are fairly nicely documented cost offsets. In the medical care sector as well, the nonpsychiatric medical care sector, where certain kinds of psychiatric and mental health care result in cost offsets that more than make up for the cost of care, that has been provided.

Mr. MILLER. The bottom line is mental illness is seriously discriminated against in the President's plan. You don't have to say that, but the fact is that you are treated very differently within this plan, as I read it, than are people with physical illnesses.

Dr. ROBINOWITZ. I would say most of the plan, Mr. Chairman.

Mr. MILLER. You mean the other plans, they are not as well defined as this, that is why I don't know what their intent it, but in this plan it is very detailed.

Mrs. Roukema.

Mrs. ROUKEMA. Mr. Chairman, let me tell you that you seem to be confused as to why it is handled this way. It is handled this way in the President's proposal for the same reason it is currently handled this way by insurance companies and HMOs. HMOs are already using mental health coverage as a prime source of cost savings.

I mean, I am all for cutting out waste, fraud and abuse, and the people that are gaming the system, but unfortunately the real savings that are coming out of many of the HMO programs, and I think what is implicit in the President's program, are the savings that will come by critically limiting care, and this is one prime example of it.

The note that I wrote down for myself before you even asked your question was that I think we would be best served if we let the professional therapists dominate the decision rather than the cost-benefit analysis that is driving the program under the present proposal, so that you are left with either an insurance company functionary or a bureaucrat that determines whether or not the mental health program should be covered, rather than the professional therapist, whether it be in the community program or through private coverage.

But I did want to ask a couple of questions in a little different way. I am going to first ask Mr. Feltman, because I was surprised when you said the cost controllers had been allies in your setting up your program. That confused me, until you went on to explain the savings that you were able to demonstrate because of limiting hospitalization and moving towards a system of care requirements, I think you called it, which is fine, which I strongly support.

I would like to hear your comment, your response—I would be concerned that in going after it that way, under the Title IV–E program, controlling cost, you have the unintended consequences of severely limiting hospitalization when indeed hospitalization should be required in some cases. I wouldn't want to see that as the unintended consequence.

How do you protect against that?

Mr. FELTMAN. We have in the system, we really support all children getting what they need in a manner that is appropriate for them and is least expensive for the public sector. We feel like we can save tremendous amounts of money without denying any children appropriate hospital care or appropriate residential care.

There are so many children that are going into these placements for lack of more appropriate, less expensive care, because the system that we have is outpatient, which might be a Thursday, 3 p.m. appointment, or you go into a hospital. And what about everything in the middle?

Mrs. ROUKEMA. I agree with you on that. I am just concerned about the unintended consequences.

I have just returned from a conference in which we discussed at length with academics as well as Members of Congress how the so-

cial policies have failed us, however well intended, over the last 25, 30 years. I am just concerned we don't go too far, that we don't have the control there, the backstop to protect us against overeager cost controllers that are going to deny hospitalization in those cases where it really is dictated.

Mr. FELTMAN. I fully agree that we don't want to sound like we are saying: No children should be in a hospital; or, No children should be in 24-hour placements or out of home. But in the world that I have had to work in in California, the primary issue for the majority of people voting on these policies is cost control.

And I have dozens of friends who have participated in efforts to make the case on the basis of benefit to children. And I will tell you, when it gets down to the final rounds of decisionmaking, it is out the window. And one of the things we have learned is just how much it really does cost the public sector to take care of these children because they don't have local mental health care. And that is the first time people paid attention to us, is when we started talking about money.

There have been issues brought up at times like: Why don't you talk about something other than money? Well, we learned early on the hard way that if you don't talk about money, people get bored and they don't do what you want to do.

We want to benefit children and save money, and we are in an unusual circumstance where keeping children with their family and in school and out of jail does both. And we can prove it with evidence.

Mrs. ROUKEMA. I have two other questions, and they are questions that I really must ask for my own benefit.

Ms. Wessendorf, the programs that you described are really admirable. Do your clients cover the cost through existing health insurance programs? How are those costs covered, for the most part, in your experience?

Ms. WESSENDORF. Are you talking about project WRAP, the example I gave, or are you talking about my own home setting?

Mrs. ROUKEMA. Well, you used—well, both, I guess.

Ms. WESSENDORF. Okay.

Mrs. ROUKEMA. Both. You use the example of Tom but you went on to describe a more comprehensive program. Your clients, are they mostly covered through private insurance coverage?

Ms. WESSENDORF. I think it is whatever the parents have available to them. So within the system, each individual child is looked at differently and paid differently depending on the parents' situation or the foster care or whatever system they are in.

I would say the majority of it, probably, yes.

Mrs. ROUKEMA. Probably yes. Thank you.

And now, Dr. Robinowitz, I do want to ask you this, because I don't know whether you have been subject to it but I certainly have been subject to it a lot. It is not a partisan issue either; I hear it from Republicans and Democrats alike.

How do you repeat the assertion that what you are proposing in terms of nondiscriminatory coverage and the extent of coverage that you have outlined, how do you refute the assertion that what you are proposing is Cadillac coverage, and we can't afford it any-

more, and we are not going to do it and we are going to start controlling these costs, we don't need Cadillac coverage in this country.

Dr. ROBINOWITZ. I think rather than refute or accept it, to look at medical care, health care in general, we have not said, for example, we are not going to cover cardiac bypass surgery, which is much more expensive than medical management or less invasive techniques such as angioplasty. We say we are going to cover what is needed for that particular patient. We don't regard that as Cadillac care. We regard that as a medical necessity.

I think the point we are making is that what we are talking about for these youngsters and their families, it is what is necessary for them. What is necessary may be bicycles at some advertisements, may be sports cars at others, but it is what is medically indicated, and has to do both with the short-term strategy, where you may have something which brings you more up-front dollars but may be a lot less costly in the long run than long-term hospitalization, than incarceration.

It is a little bit like lithium, which has changed the pattern of treatment of manic-depressive disorder, not just in terms of hospital care or medical care, but also people are out in the community working and paying taxes.

So I think we have to look at this more broadly and not get caught up in the rhetoric, which I understand where it is coming from, and the fear of potentially bottomless pits for any kind of medical care, but where we are looking at care which is medically indicated, which I think in the long run will be not Cadillac care but just necessary care.

Mrs. ROUKEMA. Dr. Knitzer? I saw you nodding in agreement.

Ms. KNITZER. I think we are really in an ironic situation where in these systems of care we are doing what health care reform says it wants to do: We are providing better services, mental health service, and managing costs. But for children, it means look at these multiple streams, as you were saying.

That is why I think it is such a hard sell, because if you look at it through a single system, which frankly we did for years, we used to talk about child welfare, juvenile justice, all separately, until we figured out it is the same kids, and it was largely the Federal dollars that were creating the walls.

But we are managing now to control the costs. We are reducing hospitalizations for this population of kids. Certainly we are seeing that in the Robert Wood Johnson sites. We are not denying children access to the most intensive out-of-home care when they need it. And we have examples of that all over the country now.

And so I think we are also concerned that we not go backwards.

Mrs. ROUKEMA. Thank you.

Thank you, Mr. Chairman.

Mr. MILLER. Ms. Woolsey?

Ms. WOOLSEY. Thank you, Mr. Chairman.

And thank you. What a wonderful panel this has been.

I definitely agree that we need to have uniform coverage and treatment of our children, including and particularly emphasizing mental health, and it must be part of whatever health care we have. And we ask the question of why it is we are putting restraints on mental health, because of the fear of a bottomless pit,

the things that comes to me immediately is the bottomless pit is homelessness, prisons, suicide, having a workforce that is not ready for the 21st century. That is a bottomless pit, and that is where good mental health for our youth and our children will make the difference. And we have to get that message out.

I believe that very strongly, that the single-payer health care reform is going to be the best way to cover everybody in America, and particularly our children and their mental health needs.

I have also made an effort in our Elementary and Secondary Education reauthorization to make sure that the special needs of children are noticed and treated early on, and that is through coordinated services at or near school sites, so that families can have the services, social and health, they need, where it is available to them and effective and efficient for them.

But I have plans for adding the school-based health services, including counseling services, to an amendment which Representative Miller will soon be introducing to the American Health Security Act, so that we can make sure that we aren't just looking at ESEA, we are looking at the American Health Security Act in providing those social services and health services at the school site.

I have some questions, and I don't want to go on and on talking about me because I have things I want to know from you. Can you address the access of mental health services to runaway youth? How adequate or inadequate are we in addressing runaway youth?

It is hard enough when they are already in school or part of a family situation. Do any of you have programs or recommendations?

Mr. FELTMAN. The points of entry for children are very important into the system in terms of accessing mental health care. Children who run away generally don't function independently over time. They enter one of the public sector systems, usually not the mental health system. They enter the juvenile justice system or the social services system. And at the community level, to the extent we are integrated into those systems, those kids then have access to those services that are.

In the communities where this is treated as an independent social problem, just like education and juvenile justice and mental health and anything else, these kids don't have any access to mental health care, and many of them do have histories of suicide attempts and substance abuse and serious learning handicaps and emotional problems. So the issue of access points me in the direction of a system of care again. If mental health is integrated at the local level into these other systems, runaway kids will have access. If it isn't, they won't.

Ms. WOOLSEY. Anybody else want to respond to that?

One of the other concerns I have is guaranteeing patients' privacy, particularly for our youth. I mean, they could be carrying some very heavy-duty messages if we are not very private with this. How do you handle that with your local programs, and how are you protecting them?

Ms. BUSS. I can just speak on behalf of the clients we represent. It is indeed a very important issue, particularly when children get mental health diagnoses, which opens the door to services. Ironically, there is a push to diagnose kids more quickly, because it is

a way to get services more quickly, and then you have this heavy diagnosis that follows you around as a child.

One thing we have learned there seems to be an assumption that privacy is better protected if you keep the systems separate. The one thing we have learned is that is absolutely not true. The systems do an equally bad job or good job, and the fact that the systems are coordinated does not seem to have an effect on how well the privacy is preserved.

What we do is make sure the client understands that they are making—essentially there are sometimes tradeoffs, that with the diagnosis may come opportunities for treatment, but the exchange is they may be publicizing that they have a particular kind of need.

If the services are good, the diagnosis or the information is much less threatening. It is extremely threatening to have a diagnosis if that means you are going to end up in a locked facility. If the services are good and will actually give you treatment that will help you stay with your family, my experience is that children, as adults, are pretty open to sharing the information with the people who would need to know to put an effective plan together.

Ms. KNITZER. I think that is really important, because for years we talked about privacy, we meant that one system couldn't talk to another, and as a result nobody knew what was going on. And I think we have in these common systems of care, particularly with the common planning process, so it is not just one private, for example, physical therapist but it is a team sharing the crucial information, and with the permission of the child, depending upon the age, and the family, we have found that results in more effective services, and in some instances confidentiality has been a barrier as opposed to a protection for children.

Dr. ROBINOWITZ. This may be a gratuitous comment, but I think we have worked to decrease some of the stigma of mental disorders. There is confidentiality for all medical conditions, but the particular hit for mental illness can be dealt with as the stigma decreases.

Ms. WOOLSEY. That is probably the bottom line, isn't it, to that answer.

Dr. Robinowitz, you referred to psychiatrists. I want to ask you and then get some response from the rest of the panel, are we only talking about psychiatrists? Are we looking at alternative, alternate providers, psychologists and social workers and caseworkers that are at different levels capable of support and diagnosis and work?

Dr. ROBINOWITZ. I am speaking from a psychiatric perspective, but as a clinician it is clear to me we need all sorts of health care, mental health providers, both MDs and others. So we are talking about the demonstrated shortage of psychiatrists, in particular child adolescent psychiatrists, and we are talking about psychiatrists. But when you talk about flexibility of care and continuum of care, you need to talk about different caregivers with different levels of education and experience, who pick up different pieces.

You weren't here, but I think we heard earlier this morning examples of different kinds of caregivers, and I think the presentations emphasized that you need a variety of caregivers, particularly for these complex problems. You wouldn't talk about the care

of a diabetic child simply by talking about an endocrinologist. You need to talk about all the other folks who participate in the care.

Ms. WOOLSEY. Do you think, in looking at the President's health care reform, that we have gone far enough to ensure that alternate providers would be available in the mental health system? Have you looked at that?

Dr. ROBINOWITZ. I am more concerned with the President's proposals that have to do with placing caps on the training of nonprimary care providers. The 55 percent residency training slots for primary care physicians does not then take into account some of the areas in which there is a big shortage, such as child psychiatry.

My concern is that dealing with one need, need for primary care providers, which none of us argue with, we may overcompensate, which Mrs. Roukema mentioned, the whole notion of—you don't want to have lack of access to hospitalization for that percentage that needs it. You don't want to, by fixing one piece that is not working well, mess up the rest of the system.

So that has been my concern. I think there are concerns about manpower, but I think what is more the issue is access to flexible care, benefits of care, and I think—I also have some concern that some of the managed care activities that deal more with cost containment than outcome are concerned with getting the cheapest possible provider, which is not a psychiatrist, which is not a psychologist, which may not even be a social worker or nurse, but may be one provider which is at the cheapest cost to that particular managed care program, and then not want to add what seems like a lot of up-front costs that may be cost effective in the long run.

Ms. WOOLSEY. Anyone else want to respond to that?

Mr. FELTMAN. I agree with Dr. Robinowitz very much. The debate that I hear on television and in the newspapers about health reform seems to focus first on services in the package, as though that is the thing that we want to decide on, or a second dangerous pitfall, I think, is the providers, and every special interest representative group would come in and say: We should be in and they shouldn't be in and we can fight over that.

That is all about funding methods and interest groups. The alternative is to fund outcomes and communities to achieve specific goals for our high-risk kids that are already in the public system. And we are going to pay for it one way or another.

So I think that is a distraction, to get into deciding—realizing that there are a variety of professions and disciplines that can make a contribution to Mrs. Davidson or to a family with a child who has a serious emotional problem, to get into trying to decide, first of all, are we going to do outpatient/inpatient day treatment, or something else, and then are we going to allow nurses to do this? That really is a mistake, in my opinion, if you are considering outcomes as the basis for determining value for tax dollars spent.

Ms. WOOLSEY. Thank you very much.

Thank you, Mr. Chairman.

Mr. MILLER. Mr. Strickland?

Mr. STRICKLAND. Thank you, Mr. Chairman.

Thank you, members of the panel.

I was sitting here with a lot of conflicting feelings as I listen to you, thinking of human beings that I have known in my life who have been affected in one way or another by the kinds of things we have been talking about this morning.

I have wanted to say, though, that as far as what the Chairman said regarding the President's health care plan and its discrimination against those with mental disorders, I think that is true, but I will tell you what really concerns me is that most of the plans out there have no specific reference to mental health treatment or treatment for the mentally ill, and that I am very concerned that while the President's plan does not go far enough, at least there is a very specific commitment to mental health treatment that I don't see anywhere else, with the exception of the single-payer plan, and as we start looking for ways to save money, I think that is going to be a very definite target.

I also would like to make a comment in regard to the need for inpatient care and the desire to save money by avoiding it. I have personally—in fact, since I have been a Member of Congress—been involved with situations where an adolescent needed inpatient care and at least in my judgment, in the judgment of several other professionals, was denied that treatment because it is so expensive. And so I think we can adopt the philosophy of treatment that can be taken to an extent that it interferes with our ability to even accept the occassional need for inpatient care. And that troubles me.

And then having worked in a prison, I can tell you that we are not saving money; we are just changing institutions and we are changing where we are spending those dollars. I worked with young people who were so severely disturbed and who had literally grown up in State psychiatric hospitals until they were late adolescents, kicked out into the streets with no skills, no support systems, no families, and expected to make it, and ended up breaking into a supermarket or doing something and being incarcerated and then facing the rest of their adult life as incarcerated persons. Because once you are incarcerated and you have a sentence of like five to 25, or you know how these sentences go, and you have got a mental illness, you stand a good chance of serving your entire sentence, because there is a reluctance to parole someone who has a psychiatric disorder or a psychiatric history.

It is shameful what is happening in this country today. It is absolutely shameful. And it troubles me, as a mental health professional myself, that sometimes those of us who are have been silent in speaking out about this.

The question I would like to ask you is, it takes a particular kind of training and skill to work with disturbed children, and obviously we aren't providing an adequate number of child psychiatrists. That is just glaringly evident. But what about other mental health professionals who are capable and skillful in working with children? Do we need to do more to make sure they receive the kind of attention they need?

Ms. KNITZER. I don't have the numbers. They are easily gotten, about the shortage, for example. I am a psychologist. I know that there are not many psychologists who—it is difficult to work with this population. I think that is true of all mental health profes-

sions. There are many people who would choose not to, and those who do tend to be a very dedicated bunch.

We have a twofold problem. We have a shortage of mental health professionals across the areas, and then we have mental health professionals who are in some sense mistrained. This is true of social workers and teachers as well, because we are training with boundaries and not in this collaborative way we need to be training them.

But I think the issue of shortages is crucial, and I know in the Robert Wood Johnson sites, the child psychiatrists are playing a crucial role, sometimes being the ones to say to the inpatient psychiatrist who is unfamiliar with alternatives: Yes, we can handle this child in the community and we can provide the medication and we can wrap services around. And I think in some places where there are no child psychiatrists, psychologists are playing these roles, and I think we are beginning to see more people who understand this new way of working, but it is an enormous—both person power and training challenge.

Mr. STRICKLAND. Thank you.

Mr. MILLER. Let me ask you something. As we consider this benefit, the mental health benefit within the context of health care, is there any concern among some of you that if we buy into that approach, and it looks something like—and the President's bill or any other bill will have limitations on this benefit—that that becomes the mental health system, and these other systems now start to have resources withdrawn from them because the theory is the benefit is available, but in fact the benefit is not available in any comprehensive fashion that it is today, that you constructed under early periodic, or that you have constructed under the Ventura model, which provide a wide range of services to these individuals, or is available under education for the handicapped, where school services have to go out in some instances and procure those services, that when we move from this system to that system, an awful lot of resources are lost in that transition, because as categorical, if I can use that term, as they are under the President's plan, they simply are not going to provide the array of services necessary?

Ms. KNITZER. Also, the incentive for doing some of the pooling is to use it as a Medicaid match, so that has brought some of the other systems to the table, some of these systems of care, and if we lose that incentive or any other incentive, I think it is a real danger.

Mr. MILLER. At what point do the States say: It is provided under national health care, and of course it is not?

Dr. ROBINOWITZ. Also, if it overrides State mandates, you then have a problem where States say: We have been overridden, we don't have to do this anymore.

Mr. MILLER. Is this a matter of real concern?

Ms. BUSS. I think any program for providing mental health coverage that is not tied to medical necessity, focused on what is medically needed for a child, and that is capped, is extremely threatening to all these programs. If whatever the program—whatever the heading is, the treatment to which children are entitled is connected with what their medical need is and is uncapped, the other systems can use that funding.

That is what I brought up before with the SET funding. We would rather not have it categorical. If it is tied to the mental health need, it can be used in a lot of systems. It can't be if it is tied to something else or if it is capped.

Mr. FELTMAN. I would just like to echo that. This is a very threatening issue for those of us who have been beginning to collaborate with each other and beginning to successfully take advantage of opportunities in Federal Medicaid and Title IV and some of the educational categorical pots that actually have been made more flexible to promote integration of services and outcomes.

If, as a consequence of health reform, Medicaid restricts its application of mental health benefits, or Title IV, or some of these other categories, they say: It is done over here, we are done. And we are back to those outpatient hospital days or whatever is included as it is phased in in health reform. And I think most of the people who are looking at health reform don't understand yet what is going to happen is the seriously disturbed kids who need more than a few outpatient visits or one episode of hospitalization, a year maximum. It is very scary.

Mrs. ROUKEMA. I have another question that is somewhat related, but it seems to me we have inadvertently ignored an important component of this, and I think I am going to direct the question to Mr. Feltman and Dr. Robinowitz just for their reactions.

We haven't made any reference specifically to the National Health Board. Some of the things we have talked about here have been alluded to as defined by the National Health Board, but they are given really very broad authority.

Based on your own experiences, in your respective responsibilities, what is your view of the National Health Board role, and your assessment of it or the cautions or endorsement that you might have? I have, needless to say, severe reservations about it.

Dr. Robinowitz?

Dr. ROBINOWITZ. Well, again, I think the problem always is, when you have folks who are not familiar with what is needed, what can be provided, you either have an immensely steep learning curve, which I think probably is unlikely, or you have the danger of tunnel vision or missing points. We see how complex these issues are. We have a bunch of professionals sitting here talking about complexities, and it is my experience in working with mental health boards in various communities that they tend to look at dollars, they tend to look at big picture items.

Now, if the big picture items are flexible enough, you can work underneath that and do what needs to be done, that is fine. But I think what we are all saying here really has to do with, can we have a system that puts medical necessity for these children and their families as a top priority. If that can be done within the health board, terrific.

One is always anxious about——

Mrs. ROUKEMA. Yes, but do you want the health board, for example, determining what is suitable for inpatient treatment and what is to be covered by intensive nonresidential services? That is just one example.

Dr. ROBINOWITZ. You obviously know the answer, which is I think——

Mrs. ROUKEMA. I want it on the record.

Dr. ROBINOWITZ. None of us wants that unless—in a way we have Congress doing that. Congress can do that because Congress——

Mrs. ROUKEMA. Medicare?

Dr. ROBINOWITZ. Right. A lot of input from the various professions, from patients, from advocates, and can look at important clinical information, can look at a number of other factors other than just cost. You would have to do that with the health board, which produces a whole layer of education. That worries me, that scares me.

Mrs. ROUKEMA. Mr. Feltman, your experience?

Mr. FELTMAN. Since we don't have a health board now——

Mrs. ROUKEMA. I mean, based on your experience, what is your assessment of the health board's role?

Mr. FELTMAN. There is a good side and a bad side. The bad side is any time a one-size-fits-all structure is established focusing on methods applied to different communities, we are going to have a problem.

The good side is that I think we do need to have some kind of policy body that we can bring issues as they develop, because obviously things will need to change that focuses on this, and also some points of authority that will judge our performance. And I am a little worried about a health care plan that will be essentially an insurance package with no point of authority to engage—for instance, would we have the performance contract with the County of Ventura after health reform? I mean, where would we go to say: We can do this this way, and then persuade somebody that that is a good use of money, and then enter into a performance contract?

Without some board at the State level or wherever that is a point of authority, I think we are now down to every person for themselves, everybody has these benefits and every provider is on their own and we all kind of go off in separate directions.

So I am looking for accountability. I think we can handle it. And I don't understand the National Health Board's role in that. But I certainly am not interested in a one-size-fits-all kind of this-is-the-methods-to-do-it thing.

Mrs. ROUKEMA. Thank you.

Thank you, Mr. Chairman.

Mr. MILLER. This has been a very sobering hearing. As I look at the model again—and again, I don't mean to be critical in that sense but it is the only one that is laid out in detail, is the President's plan. For most of the kids that people in my congressional district struggle with in the school system, in the juvenile justice system, and what we call the mental health system, which is, you know—this is completely inappropriate to their care, what is outlined in this health care package. It is completely inappropriate.

There are facilities that will be able to take advantage of this, because again, out of desperation, you will seek out a locked facility where you can get 60 days of respite by having somebody locked up, or 30 days inpatient, whatever are the conditions that are finally laid down. But that has little or nothing to do with the care or long-term recovery or maintenance of an individual with these problems. It is simply inconsistent.

So I am kind of struck this morning that we are buying into a very old, discredited model of mental health. It is because most policymakers cannot visualize a mental health care system. They can visualize if you say HMO, preferred provider, it will be gathered around a hospital, there will be some office buildings, all of these things exist, whereas they are unable to visualize a system that provides the array of services, because in the community of mental health, it is an array of services that can be from drop-in programs after school to locked facilities, to group homes, to foster homes, to specialized foster care. It can be a whole array of services that accommodate the needs of that individual, and yet that is a very foreign experience, I think, for most policymakers, than visualizing how the private hospital is going to transfer itself into an HMO.

If the requirement of the law is that you had to handle the mental health care of an individual in 60 days, that one doesn't quite work. You know, we are all sort of—we have great gratitude for the President and the First Lady and the Vice President's wife, Mrs. Gore, for raising these issues and making this a part of it. But this isn't going to work.

I think what it is going to do is eventually you will lose the Title IV–E funding, the Title XIX funding, where we have knitted together in some cases a very comprehensive plan and in other cases catch-as-catch-can. Doesn't there have to be a parallel effort to take what we have learned out of the Robert Wood Johnson programs, what we have learned out of the Virginia experience, and the family preservation, the most recent one, what we have learned out of Ventura County, to construct that mental health system?

It is really a lot of caseworkers using the phone to try to find services, and either you get it or you don't get it. If you are clever, you can fax and get a reservation for tonight because you have heard somebody is getting their kid out of there, people constantly in motion trying to find a system. That is the mental health system. That is not acceptable, and that is not going to be converted in what is outlined in the President's bill.

Mr. FELTMAN. Could I make a quick comment about that?

Early on in the development of that bill, there were the work groups that were set up. Mrs. Gore chaired a mental health work group, and within that there was a children's mental health work group, and I knew some of the people on that and I had a chance to have some input.

The discussions and the input into that work group was very similar to what was decided here. And everyone went forward from those work groups through the tollgates that Mr. Magaziner had established with an understanding that we were moving toward a system of care for children at the community level.

Something happened between the discharge of Mrs. Gore's kind of work group recommendations and this conversion into X number of days of this benefit and X number of outpatient visits. And I am sure it has something to do with cost.

Mr. MILLER. This was sort of a placeholder for what will evolve as the mental health benefit. But that is becoming less and less so, it seems to me, because they are being more and more wedded to this approach, which, as Dr. Robinowitz points out, where you have these tradeoffs, four days to one day, three days to one day, that

is sort of an internal cost containment system, that they are hoping will move people from one system to another, but again, has nothing to do with the treatment that that individual may need.

And when you have cashed in all your days, then what do you do? I sound like Marge's witnesses here. Well, unfortunately this is one of those hearings that I think has raised more questions than it has answered, other than what each of you have told us, that clearly that model is out there, it has been developed, it is utilized all over the country, it is not utilized on a comprehensive basis, but obviously community after community, State after State is moving or has arrived at this point in terms of trying to provide these services.

It would seem to me that the discussion better be had about how that is continued on a parallel track so there is somebody to contract with. Because otherwise there is nobody out there to contract with, because I am afraid these other services start to fall apart.

Let me ask just one final question of you, Ms. Buss. How common do you think it is to be able to take the early periodic program and put together the array of services that you describe for the two clients that you had?

Ms. BUSS. How common is it to be able to or how common is it that it is happening now? Because I would give very different answers. It is very—the funding stream is available for all children who are Medicaid eligible, and as you know, Medicaid eligible children is a broader group than has been true in the past. For example, in Pennsylvania all children in foster care are Medicaid eligible, basically 99 percent.

Whether it is happening, yes, it is just starting to happen, people are just starting to figure out how to use the funding stream. I gave another example in my written testimony. It doesn't occur to the various systems that are traditionally responsible for these kids to turn to EPDST funding. And we have been doing a lot to educate State officials on what this funding stream offers. So it is a very broad opportunity, fairly narrowly used in places at this time. It is just starting to be used more broadly now.

Does that answer your question?

Mr. MILLER. Yes. I guess when I read your testimony this morning, I was thinking, that looks more like the system you would say you want in terms of the flexibility to go out and to individually develop that case plan for that individual and/or that family, in terms of their needs. That would look more like the benefit you would want plugged into a national health care system.

Ms. BUSS. Yes, absolutely. And the concern, of course, that it has been limited to Medicaid eligible children, which is basically low-income children, although for children, it is now, as I say, higher levels

Mr. MILLER. But if I had to hold on to one system or the other, it would seem to me I would be better off holding on to that system as opposed to taking it—there is some discussion about folding Medicaid into Medicare and then into national health care. If that was the mental health care benefit that they have outlined in their program, that is not a fair swap.

Ms. BUSS. Yes. It is a much better mental health and medical benefit. I think the people who argue for the folding in, aside from

cost containment issues, will raise issues of not wanting to segregate how low-income children are treated and not wanting to stigmatize people with the label of Medicaid, but I say figure out something else to call it and let the medical need drive the service, because it is a much broader, more flexible——

Mr. MILLER. Is this being used in California in that fashion?

Mr. FELTMAN. Yes. It is one of those Federal sources that has really—and probably in the last five years, begun—we have had revisions of our State plan, and EPDST is becoming a very important piece of it.

The missing piece in EPDST is accountability. It is a flexible method of securing what children need, but there are concerns that how do we limit that, and because it is limited strictly for the children that are on Medicaid, that, you know, there is some limitation. With the expanded, there still needs to be some way of incorporating performance variables into a package like that. But that is the kind of thing I am afraid we could lose.

Ms. KNITZER. There is one other piece I think we need. It is not only the fiscal. It is having a structure to facilitate this resource sharing and clinical sharing across the different systems, so that it is not just everybody finding for this kid an EPDST package of services, but there be some kind of a community vehicle to look at the administrative issues, the county share, all of those kinds of issues.

We need a forum. We are finally talking to each other. And if that goes, if you were, for example, to contract with health care entity, whatever the "it" is, whatever the involvement at the table of education and child welfare, you would not still have the Ventura system of care. You would have something else.

So it is not just protecting the flexible dollars and the flexibility services. It is also, I think, creating some incentives for this cross-system collaboration. That actually is an issue we have to look at in Title IV--E and all the other programs as well, so that we are all singing the same sort of structuring.

Mr. MILLER. Everybody is singing it. They are not quite doing it.

Ms. KNITZER. A little off key.

Mr. MILLER. That is the accepted direction we have to go in providing services to these kids. It is not being done on a comprehensive——

Ms. BUSS. I would argue it can't be done unless the flexible funding is out there. People can come to the tables and talk all they want. They will stop coming to the tables if they can't create wrap-around programs for children that meet the need. It is very connected with the willingness of systems to sit down.

Mr. MILLER. People who are currently enrolled, people like myself, I am in a Federal employee Blue Cross plan. Under the President's program, where do I go to get those services? If my children need this, or anybody, any normal family that has some kind of health insurance or they buy into this plan, where do they go to get those services under the President's plan?

Mr. FELTMAN. They go to their private provider until they exhaust their limits, and if they had serious problems, as soon as they exhaust the limits, they come to their local county mental health department, and we are seeing more——

Mr. MILLER. Most providers today are not set up to provide mental health services.

Mr. FELTMAN. No. They get outpatient, inpatient.

Mr. MILLER. That is why you get 30 hours and 30 visits. If you can go out and find it, they will reimburse you for it, but it is not like the maternity ward. It is not like a service which is there. You go out and find it, and if that doctor, psychiatrist or social worker or what have you is on their list of people, they reimburse you. You have constructed that yourself.

These kids and their families, you know, they have got to go back out in the community, construct their service, come back, and then it is not fit for reimbursement because it is not related to the outlines in the President's plan. Right?

Ms. ROBINOWITZ. It puts a lot of pressure both on the individual provider to do that, for which she or he won't get reimbursed, to set this up for you, or to connect through the school system, through some other system, and then you run into the problem, as you say, there is no reimbursement for this.

Mr. MILLER. But the provider is not going to do it. It is not in their financial interests to do it. They will let you go construct the services and then they will simply tell you whether or not you are going to get reimbursed, at what rate, for what length of time.

Dr. ROBINOWITZ. Unfortunately, being a child psychiatrist and having done a lot of work with children who are developmentally disabled, often it was the child psychiatrist who ended up doing it, and that may be one of the reasons why child psychiatry is so low down in medical income, because it takes an inordinate amount of time, and most insurance programs do not cover even a little bit of this. They will cover a time when you are in a room with a child, maybe when you are in a room with a family, but the time you spend dealing with the other providers and trying to work out a system for this child may not be covered at all.

So that becomes a very powerful disincentive, so you tend to use a system that works, in quotes, you know, an historical system which may or may not work for this particular child and family.

Mr. FELTMAN. A core component service of a system of care is mental health case management, which is what Mrs. Davidson was talking about needing. It is somebody that allies with a family member to follow a child over time and across agencies to get whatever that child needs. And it is a mental health case manager because they have clinical skills to determine what is appropriate. It isn't an insurance case manager that essentially looks at only managing costs over time, not care over time. That is what is missing in the insurance case management component of this.

In a system of care, we have clinicians, nurses and social workers, that are managing care over time to see to it that they get access to what they need as well as costs controlled.

Mr. MILLER. Well, thank you very much for your testimony. But I think we would do well to temper our gratitude with some very hard thinking about what system is going to evolve if national health care comes into play, and with this kind of mental health benefit, what is going to happen to the public side here. So many people never think they are going to need public service. This is one area where you dive right into public services because that is

all that is available out there, at least in the areas I represent, and whether or not that is going to be dramatically diminished by this benefit as it is currently outlined.

Thank you very much for your testimony and for your help.

The committee stands adjourned.

[Whereupon, at 12:30, the subcommittee was adjourned.]

[Additional material submitted for the record follows.]

The American Psychological Association

The American Psychological Association appreciates this opportunity to submit a statement for the record of the February 22, 1994 hearing before the House Education and Labor Committee, Subcommittee on Labor-Management Relations, on children's mental health. Our statement will be focused on the need for comprehensive mental health services for children.

THE NEED FOR COMPREHENSIVE MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS

There is a tremendous unmet need among our nation's youth for comprehensive mental health services. Approximately 20 percent of children and adolescents, or over 14 million youth, have a diagnosable mental disorder, yet only two to six percent of all children receive some form of mental health care. Of those children with severe disorders, between 70 and 90 percent are not receiving any treatment (Costello, Angold, Burns and Leaf, 1992; MECA, 1993; Burns, Taube and Taube, 1990; Bickman (1993).

Further, the incidence of mental and emotional disorders in children falling under our state systems is extremely high. A recent survey of 45 states performed by the National Mental Health Association found over six million children in need of state mental health services. Of the 430,000 children in our nation's foster care system, between 50 and 85 percent have a diagnosable mental or emotional disorder. And, of the approximately 94,000 adolescents detained in juvenile justice facilities, over 60 percent have mental health or substance abuse problems. Prevention and intervention services in these settings are not readily available, and children must often exhibit severe symptoms before receiving treatment.

Of those mental health services to children that are available, problems exist in that they are fragmented or overlapping. Even though targeted at identical children's problems, funds from health, mental health, special education, juvenile justice, and child welfare agencies are often inflexible and uncoordinated.

COMPREHENSIVE AND COORDINATED BENEFITS MUST BE MADE AVAILABLE TO ADDRESS THE MENTAL HEALTH NEEDS OF CHILDREN AND ADOLESCENTS

A wide array of outpatient and inpatient psychological treatment interventions are available and proven to be effective in treating children and adolescents with mental illness and substance abuse addiction. It is crucial that any benefit package include these services, specifically targeted at children and their families, and that these services emphasize prevention while also including early intervention and other appropriate treatment modalities. Children and their families must be able to access these services across a wide range of community settings so that treatment in the least

restrictive setting is possible.

Comprehensive systems of care for children and adolescents are becoming more available and are proving to be effective. These systems are appropriately more broad-based, building on the current school and primary health care systems, and emphasize individualized treatment and coordination between the various public agencies and programs. A recent compilation of outcomes from such systems of care illustrate, for example:

- reductions in out-of-home placements;
- reductions in length of stay in inpatient settings;
- increased use of less restrictive and more appropriate placements;
- improved functioning both globally and on specific behaviors;
- improved school attendance and performance;
- reduced contacts with law enforcement; and
- increased parent participation and support (Stroul, 1993).

Such comprehensive approaches to children's mental health are also proving to be cost-effective. For example, the Impact Program in Kentucky illustrates that it is less costly to serve children and adolescents with a range of comprehensive, community-based services than under the previous less comprehensive system. It is estimated that under Impact, per child costs have been reduced by about $4,300. Further, in addition to reducing actual treatment costs, comprehensive systems of care for children and adolescents reduce costs in other areas. In Ventura County, California, a comprehensive system of care reduced youngsters involvement in the child welfare, criminal justice, and psychiatric hospital systems, realizing a savings of $2,873,981 from 1985 to 1988.

Such reductions in associated costs point to the need for preventive services and the cost effectiveness of comprehensive mental health and substance abuse services. Preventive mental health services for children and adolescents are key, and should be incorporated into any package of services. For certain problems, such as child maltreatment, preventive approaches are obviously preferable to remedial treatment and more cost-effective. For example, parent training and in-home family support therapy is far preferable to the need for child protection services, foster care, legal involvement and the general disruption of family life.

OUTPATIENT MENTAL HEALTH SERVICES ARE AN EFFECTIVE MEANS OF PROVIDING HIGH QUALITY, COST-EFFECTIVE CARE TO CHILDREN AND ADOLESCENTS

Outpatient mental health services, and outpatient psychotherapy in particular, are generally as effective as inpatient services and

can be delivered at a fraction of the cost. These services can be particularly effective in treating children and adolscents, where treatment in the least restrictive setting with involvement of family members has been shown to be particularly effective.

Our current system has been structured in such a way as to provide incentives toward more expensive inpatient care (e.g. coverage of inpatient care at at least 80 percent, often 100 percent, while outpatient is not covered or covered at only 50 percent) or coverage to medicate. It is thus not suprising that when faced with a crisis, many families would turn to the inpatient setting for treatment of a child or adolescent with mental health or substance abuse disorders. This has resulted in increasing costs in both the inpatient substance abuse and inpatient adolescent treatment areas, the only areas in mental health care in which costs have been on the rise. It is thus essential that our current system be reformed to provide incentives for effective, less costly outpatient mental health care.

Children and adolescents can be particularly well-served in the outpatient system, as this setting lends itself more easily to a comprehensive approach and is less intrusive and disruptive to family life than inpatient hospitalization. Family involvement, which is crucial to the recovery process for any child, is affordable and more easily accesssed in this setting. Ongoing outpatient family systems therapy is often required and provided in conjunction with outpatient therapy for the child. If a child or adolescent from a dysfunctional home is placed out of the home and into the inpatient setting for 30 or 60 days, once returning to the home the problems will likely resurface. An outpatient approach more easily addresses the whole problem -- both the child and the home setting.

Many children and adolescents who are currently placed in inpatient settings could be more effectively treated, at lower cost, in the outpatient setting. For example, because of the violence in our society and the deplorable conditions in which many children are raised, more and more children are exhibiting symtoms of Post Traumatic Stress Disorder (PTSD), a serious disorder which until recently has been more associated with war veterans. PTSD requires long-term therapy, but there is no need that this therapy be provided in the inpatient setting. Outpatient treatment for children and adolescents suffering from trauma has been shown to be highly effective, with great cost savings resulting.

Children and adolescents with Attention Deficit Disorder (ADD) are also well-served in the outpatient setting. Early psychological intervention in the form of consultation with teachers and parents and outpatient psychotherapy can effectively prevent these youngsters from becoming disenchanted with the school system, can prevent behavior and self-esteem problems, and ultimately decrease school drop-outs. This treatment is often provided in conjunction

with medication to address the biological aspects of the disorder, and focuses on teaching these children and adolescents coping skills. The cost of such treatment is minimal, particularly in light of the enormous costs -- both human and societal -- of not treating the disorder or inappropriate treatment.

Additional alternatives to inpatient care, for example, partial hospitalization, day treatment, or group homes, should also be made available to children and adolescents, particularly when they are used as a means of phasing out or avoiding the inpatient setting. These services can be very effective when used carefully, so as not to disrupt family life and the child's support system. Such services should be a part of a standard benefits package, enabling each child access to a full continuum of care with treatment in the most clinically appropriate setting.

The American Psychological Association is concerned with the limits placed on outpatient visits (limited to 30 per year) in the President's plan, and are fearful that with such limits, many children will either fall through the cracks or be forced to rely on more expensive and clinically inappropriate inpatient treatment, which may lead to greater disruption of family life. We applaud the President's inclusion of actuarial substitution as a means of trading inpatient days for more outpatient visits and thus increasing the outpatient benefit. However, under the President's plan it will be difficult for all children and adolescents to access further needed outpatient care with health plans being given the responsibility of determining when such additional services are necessary. Given the extreme limits that managed care systems have placed on psychotherapy services in the past, we are fearful that these plans will ignore the needs of children and adolescents.

CONCLUSION

The American Psychological Association applauds the efforts of the President and this Committee in advancing health care reform. We ask that special attention be given to the mental health needs of children and adolescents, and in particular that these services be comprehensive and coordinated, with incentives built into the system to encourage treatment in the least restrictive setting. As a nation, we can foster the healthy development of children and their families by providing universal access to these important services.

We look forward to working with the Committee on this crucial issue.

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